PART II

POLICIES AND PROCEDURES

FOR

PHYSICIAN SERVICES

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

DIVISION OF MEDICAID

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Part II Policies and Procedures Manual for Physician Services

2019

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PREFACE

This manual contains basic information concerning the Physician Services Program and is intended for use by all participating providers and in conjunction with the Part I Policies and Procedures Manual for *Medicaid and Peach Care for Kids*. Part I of any DCH manual outlines the Statement of Participation for participating providers. Part II of any DCH manual outlines the policies and procedures specific to that program as well as the terms and conditions for receipt of reimbursement.

We urge you and your office staff to familiarize yourself with the contents of Part I and Part II of the manual and refer to it when questions arise. Use of the manual will assist in the elimination of misunderstandings concerning program policies, coverage levels, eligibility, and billing procedures that can result in delays in payment, incorrect payment, or denial of payment.

Amendments to this manual will be necessary from time to time due to changes in federal and state laws and Department of Community Health (the Department), Division of Medical Assistance (Division) policy. Manuals are posted quarterly on the DXC Technology web portal at www.mmis.georgia.gov and will include any amendments when such amendments are made, if applicable. These postings shall constitute formal notification to providers of any changes or amendments. The amended provisions will be effective on the date of the notice on the manual or as specified by the notice itself. All providers are responsible for complying with the amended manual provisions as of their effective dates.

Thank you for your interest and participation in Georgia's Medicaid/Peach care for Kids program. Your service is greatly appreciated.

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PART II

CHAPTER 600

SPECIAL CONDITIONS OF PARTICIPATION

601 In addition to the general conditions of participation identified in Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Section 105, providers in the Physician Services Program must meet the following conditions:

601.1 Each enrolled physician agrees to bill the Division only for services that are rendered by the physician, or for services rendered under the physician's direct supervision. Only necessary and appropriate medical services that meet the following conditions will qualify as services performed under the direct supervision of the physician:

A. The services must be performed by medical personnel who are authorized by law to perform the service, and who are qualified by education, training, or experience.

B. The person performing the services must be a salaried employee of the physician, or of the physician's group practice as defined below; physicians may not bill for the services of independent contractors.

C. The physician must periodically and regularly review the patient's medical records.

D. The physician must be immediately available on the site at the time the services are delivered, except as provided in Section 601.9.

E. A physician may not bill for services rendered by a person not approved to provide that service by Medicaid Policy, or by applicable licensure, certification, or other State or Federal Regulation.

F. Chapter 900 shall control over language in this section.

The provider must maintain an office, clinic, or other similar physical facility, which complies with local business and building license ordinances. (See Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual, Chapter 100, Section 105, for General Conditions of Participation.)

In a group practice, each physician must enroll separately and bill for services rendered under the rendering provider's own provider number. A group practice is defined as a partnership, a professional corporation, or an assemblage of physicians in a space-sharing arrangement in which the physicians each maintain offices, and the majority of their treatment facilities in a contiguous space. Services performed by non-enrolled physicians in a group practice are not covered.

Indiscriminate billing under one physician's name or provider number without regard to the specific circumstances of rendition of the services is prohibited and is grounds for disallowing reimbursement or for recoupment of reimbursement.

Rev. Oct 2017 **601.2 Locum Tenens**

Locum Tenens are physicians that temporarily take over the practice when the regular physician(s) are absent for reasons such as illness, vacation or military, and for the regular physician to bill and receive payment for the locum tenens services as though he/she performed the service. The locum tenens physician generally does not have a practice of his/her own and move from area to area as needed. GA Medicaid locum tenens policy does not apply to mid-levels substituting for a regular physicians practice. Physicians may retain substitute physicians to take over their professional practices when the regular physicians are absent for reasons such as illness, vacation and military for the regular physician to bill and receive payment for the locum tenens services as though he/she performed them himself. Payment may be made to a physician for services furnished by the locum tenens if the services are not provided by the substitute physician over a continuous period of more than 60 days.

Locum Tenens services are permitted if:

A. Medicaid member has arranged or seeks to receive the services from the regular physician.
B. The regular physician pays the locum tenens physician for services provided on a per diem or similar fee-for-time basis.
C. The locum tenens physician does not provide the visit services to Medicaid patients for a period of time exceeding 60 consecutive days.
D. The locum tenens physician must be an enrolled Medicaid provider. The locum tenens provider must have a valid Georgia Medicaid provider number.
E. The regular physician must place the locum tenens physician's provider number on the CMS1500 claim form.
F. Services provided by locum tenens physician must be identified in the member's medical record held by the regular physician and must be available for inspection.
G. Reimbursements shall be limited to services the regular physician is entitled to submit.
H. Any provider who falsely certifies any of the above requirements may be subject to civil and criminal penalties for fraud.
I. The explanations and limitations contained in subsection 903.3 apply.
J. A physician covering for another physician shall not be construed as a violation of this chapter. The regular physician must identify the services as locum tenens services.

Physicians should be aware that use of modifier Q6 by the regular physician (or medical group, where applicable) certifies that the covered visit services furnished by the locum tenens are identified in the record of the regular physician which is

available for inspection, and are services that the regular physician (or group) is entitled to submit. A physician or other person who falsely certifies any of the above requirements may be subject to possible penalties for fraud.

601.3 Teaching Physician

Services provided by a teaching physician, or resident, are eligible for reimbursement when the teaching physician, personally furnishes services; or, when a resident in the direct presence of a teaching physician furnishes the services. These services must be furnished in a center located in the hospital outpatient department of a designated teaching hospital, or in another ambulatory care teaching setting. These requirements are not met when the resident is assigned to a physician's office away from the center or home visits. Physician's fee schedule payment is made only when:

A. Except as indicated in the Primary Care Exception Rule, the teaching physician is present during the key portion of any exam, surgery or procedure for which payment is sought. In the case of surgery or a dangerous or complex procedure, the teaching physician must be present during all critical portions of the procedure and immediately available.

B. In E/M services, the teaching physician must be present for the portion of the service that determines the level of services billed.

C. The teaching physician must personally document presence and participation in the services in the patient's record.

Rev. Oct. 2014

Primary Care Exception Rule

The Primary Care Exception Rule enhances residency training by allowing residence independence and allows the physician to bill for services performed by residents without the presence of the teaching physician. The Primary Care Exception Rule applies to Family Practice, General Internal Medicine, Geriatric Medicine, Pediatrics, OB/GYN, and Community Health/Preventive Medicine.

Reimbursement is available for services furnished by a resident without the direct presence of a teaching physician for evaluation and management codes of lower and mid-level complexity. For the Primary Care Exception to apply, all of the following conditions must be met:

A. Services must be provided in an outpatient department of a hospital or ambulatory care entity where time spent by residents in patient care activities is included in determining reimbursement to a hospital.

B. Any resident providing service without the direct presence of a teaching physician must have completed more than six months of an approved residency program.

1. The teaching physician cannot supervise more than four residents at any given time and must supervise the care delivered to members from such proximity as to constitute immediate availability. The teaching physician must have:

   a. No other responsibilities at the time of care provided other than supervision of resident education;

   b. Assumed management responsibility for members seen by the residents;

   c. Ensured the services provided are appropriate;

   d. Reviewed with each resident during, or immediately after, each visit, the member's medical history, physical examination, diagnosis and record of tests as well as therapies; and

   e. Documented in each medical record the extent of the teaching physician's participation in the review and direction of services provided.

2. The range of services that may be furnished by residents include the following:

   a. Acute care for undifferentiated problems or for chronic care for on-going conditions. The following outpatient E/M codes are acceptable:

      1. New Patients: 99201, 99202, 99203

      2. Established Patients: 99211, 99212, 99213

   b. Coordination of care provided by other physicians and providers.

   c. Comprehensive care not limited by organ system or diagnosis.

3. The patients seen must be an identifiable group of individuals who consider the center to be the continuing source of their health care, and where services are furnished by residents under the medical direction of teaching physicians.

4. The resident must follow the same approximate group of patients throughout the course of their residency program, but are not

required to follow the same teaching physicians over any period of time.

Rev. Oct. 2014 **601.4** The physician shall not bill for adjunctive services provided in a nursing facility unless the service is prescribed by the member's attending and prescribing physician. "Adjunctive services" are any service provided by a physician or licensed practitioner other than the patient's primary care physician who is legally responsible for the medical care of the patient. The attending and prescribing physician's name must appear on the patient's chart.

Rev. Oct. 2014 **601.5** The physician shall bill the Division the lowest price regularly and routinely offered to any group of the general public for the same service or item on the same date of service, or, the lowest price charged to other third party payers for the procedure code most closely reflecting the service rendered. The physician shall maintain records on both Medicaid eligible and private paying patients for a minimum of five years to fully ensure compliance. The physician shall provide the Division, its authorized representatives or contractual agents, with information requested regarding fees at no charge.

Rev. Oct. 2014 **601.6** The physician shall not bill any services performed by an independent laboratory or freestanding diagnostic facility. A freestanding diagnostic facility is a facility that is independent of both the attending physician and the consulting physician, of a hospital which meets at least the requirements to qualify as an emergency hospital. A laboratory, x-ray, or freestanding diagnostic facility that is not located in a physician's office or hospital (example: independent diagnostic facility) is presumed to be independent unless written evidence establishes that it is owned by the billing physician or a hospital and at a minimum meets the definition of an emergency hospital. Services performed by a physician in an independent facility shall not be reimbursed through the physician program unless any one of the following conditions applies:

A. Any documented ownership in the practice;

B. Any documented cost associated with a lease of the radiology or diagnostic equipment;

C. Any documented contractual agreement for radiological or diagnostic services between the physician rendering professional services and owners of the equipment; or

D. Any documented concession agreement allocating costs of the equipment or practice to the physician. Example: An employer--employee relationship when the physician is a full-time employee of the facility that owns and operates the equipment and performs radiology services as part of an employment agreement may satisfy this requirement.

At least one of the above criteria must be met in order for the provider to bill the technical or global components of a procedure. Regardless of the above criteria, the

professional component, indicated by use of the 26 can be billed if the provider is enrolled in the proper Medicaid category of service to deliver these services.

A physician providing clinical laboratory, x-ray, and certain diagnostic services for the patient of another physician is not considered to be a consulting physician. A laboratory, x-ray, or freestanding diagnostic facility that is not located in a physician's office or hospital is presumed to be independent.

601.7 The physician agrees to cooperate with the appropriate guidelines of other Medicaid service programs adjunctive to Physician Services.

601.8 The physician shall immediately notify the Division's Provider Enrollment Unit in writing of any changes in enrollment status that occur, including but not limited to a new address or telephone number; additional practice locations; change in payee; closure of any individual practice; dissolution of a group practice causing any change in the Division's records; and voluntary termination from the Program. Each notice of change must include the date when the change became effective.

601.9 The physician shall bill the Division for the procedure code that best describes the level and complexity of the service rendered and shall not bill under separate procedure codes for services that are included under a single procedure code.

601.10 The physician shall not bill for services provided by a physician's assistant unless all the following conditions are met:

A. The physician's assistant is licensed by the Georgia Board of Medical Examiners.

B. The physician's assistant is be associated with one or more sponsoring physicians on file with the Georgia Composite Medical Board.

C. Services provided by the physician's assistant shall be billed under their own assigned provider number. The physician's assistant shall not bill under the provider number assigned to the physician.

Rev. Apr. 2013

D. No more than four PA s may provide services under the sponsoring physician at one time. (O.C.G.A. § 43-34-103 et seq).

E. The PA's current job description must be signed by the sponsoring physician.

F. Only medical services authorized in the PA's job description are billable to Medicaid by PAs.

G. The physician shall be readily available for supervision and shall be responsible for follow-up care. Readily available is defined as available by telecommunications (phone, pager, and telemedicine video), or in the facility.

H. All entries to the medical record must be co-signed and dated by the supervising physician within seven days.

To bill for services provided in Remote Practices Sites, the following criteria shall be met:

A. The 'remote site' shall be designated as such by the Georgia Composite Medical Board (GCMB). The 'remote site' designation is associated with the physical facility location, and not with the provider, and a separate enrollment is necessary for each approved site. A copy of the GCMB designation of a remote site is required for each provider enrolling for remote site or location.

B. The remote site must qualify as a principal office where the supervising physician regularly sees patients. Principal offices shall mean an office, clinic, or facility maintained by the supervising physician for the purpose of providing primary care services and where the supervising physician is physically present for at least 25% of the time the site is open for patient care or calls. (Rural Health Clinics and Federally Qualified Health Centers are not considered Remote Practice Sites. Services provided in these settings are not reimbursable under the Physician Services category of service.) A supervising physician may qualify more than three offices or practice settings as principal offices.

C. The supervising physician must be available for supervision at the remote site as needed and shall be immediately available to the physician assistant for consultation and supervision either in person or via telecommunication. The supervising physician must be physically present to review patient records and to personally provide patient care at the remote site as needed and at a minimum of at least twice weekly. The supervising physician must provide patient medical record review (via telecommunications) on a daily basis. All entries to the medical record must be co-signed by the supervising physician within seven business days.

D. Any patient seen on a regular basis by a physician's assistant shall be scheduled to be seen by the supervising physician at routine intervals as deemed necessary in the particular setting and as outlined in the physician application and proposed job description as submitted to the GCMB. Reimbursement of Evaluation and Management (E/M) services is limited to the level of service authorized by the GCMB in the appropriate primary care job description.

E. A predetermined plan for the initial management and referral of emergencies must be established for each individual site and approved by the GCMB.

F. The sponsoring physician bears full liability and responsibility for the PA, including but not limited to billing for services rendered.

601.12 The Physician and Physician Assistant shall not bill the Division for services rendered that are reimbursable under the programs below:

A. Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC), or,

B. Community Mental Health Program

601.13 The physician shall not bill for psychiatric services provided to members who reside in Therapeutic Residential Treatment facilities. All psychiatric services, including but not limited to testing, interviewing, consulting family therapy, group therapy, and somatotherapy, are included in the Therapeutic Residential Treatment program and are not separately billable to the physician program.

601.14 The Psychiatric Residential Treatment Facility (PRTF) provide inpatient, comprehensive mental health and substance abuse treatment services for individuals under the age of 32 and who, due to severe emotional disturbance or substance abuse, are in need of quality active treatment that can only be provided in an inpatient setting, and for whom alternative, less restrictive forms of treatment have not been successful or are not medically indicated.

PART II

CHAPTER 700

SPECIAL ELIGIBILITY CONDITIONS

There are no special eligibility conditions for physician diagnostic and treatment services. Other services available to members include, but are not limited to: Health Check (EPSDT) services for members under the age of twenty-one, hearing aids, durable medical equipment, non-emergency transportation, refractive services.

PART II

CHAPTER 800

PRIOR APPROVAL - HOSPITAL PRE-CERTIFICATION

801 Services That Require Prior Approval or Hospital Pre-Certification

Many procedures or services performed in the hospital or ambulatory surgical center setting require both prior approval and hospital pre-certification. The information provided in this Section provides guidance in determining when prior approval or pre-certification is needed. Services for members under the age of twenty-one years of age will require a hospital pre-certification or prior approval. The procedures for obtaining prior approval are located in Section 802. The procedures for obtaining hospital pre-certification are contained in Section 803. See Appendices E, L, and O for specific procedures. Appendices E, L, and O are subject to change without notice.

Rev. Oct. 2011

Prior Approval

As a condition of reimbursement, the Division requires certain services or procedures to be approved prior to the time of rendering. Prior approval pertains to medical necessity only; the patient must be Medicaid-eligible at the time the service is rendered. See Appendix E for a list of procedures requiring prior approval.

The Division may require prior approval of all or certain procedures performed by a specified physician or group of physicians based on findings or recommendation of the Division, its authorized representatives or agents, the Secretary of the U.S. Department of Health and Human Services or applicable State Examining Boards. This action may be invoked by the Georgia Department of Community Health Commissioner as an administrative recourse in lieu of, or in conjunction with, an adverse action described in Chapter 400. In such instances, the Division will serve written notice and the grounds for this action to the provider.

Prior Approval for pregnancy related ultrasounds is required after the first ultrasound, or in some cases, prior to rendering the service. Refer to Appendices E, L, and O for detailed information regarding specific procedures that require prior approval before services are rendered. Physicians should seek prior approval on any service for which reimbursement might be questionable. The ordering physician is responsible for obtaining the Prior Approval. Failure to obtain prior approval shall result in denial of payment to all providers billing for services including the facility.

Rev. Oct. 2014

802 Procedures for Obtaining Prior Approval

The physician is responsible for obtaining the prior authorization before rendering the service. Requests for prior approvals may be submitted online via the Web portal at www.mmis.georgia.gov.

A request for prior approval must be submitted at least one week prior to the planned procedure. Procedures performed prior to receipt of an approved request may risk denial of

reimbursement. Failure to obtain required prior authorization shall result in denial of reimbursement.

Reimbursement is contingent on patient eligibility at the time services are rendered. All approved requests are effective for ninety days from the date of approval unless an extension is requested and approved.

If an assistant surgeon is utilized, the assistant surgeon must also have a separate prior approval number, and must use the separate prior approval number of the claim billed per Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual. Reimbursement for services is contingent on the provider's enrollment in the Medicaid program, the patient's eligibility at the time services are rendered, and compliance with all other applicable policies and procedures.

Prior approval is not required for obstetrics.

803 Hospital Pre-certification

All inpatient hospital admissions require pre-certification, with the exception of routine deliveries. The admitting physician is responsible for obtaining the pre-certification of the hospital admission. The physician's failure to obtain the pre-certification number shall result in denial of payment to all providers billing for services, including the hospital and the attending physician. When a procedure requiring prior notification is performed in a hospital inpatient setting, hospital outpatient setting, or an ambulatory surgical center, the pre-certification number issued will be referred to as a pre-certification number not as a prior approval. Procedures performed in the office setting do not require pre-certification.

Rev. Sep. 2011 A prior authorization may be required in addition to the pre-certification required for all inpatient admissions and certain outpatient services.

Rev Jul 2009
Rev Oct. 2014 A request for pre-certification should be initiated at least one week prior to the planned admission or procedure. Approval is valid for ninety days from the date of issuance.

Hospital admissions exceeding ninety days require recertification within three calendar days prior to the ninetieth day of the continued stay.

Failure to obtain recertification within the three calendar days of the ninetieth day will result in denial of the continued stay. No recertification will be granted for any part of the continuous stay if the request for recertification is received after the ninetieth (90^{th}) day. The physician's failure to obtain the correct precertification number shall result in denial of payment. Precertification and recertification may be requested by contacting the DXC Technology PA/UM online via the web portal at www.mmis.georgia.gov or via telephone at 1(800) 766-4456.

Emergency outpatient services, vaginal or C-section deliveries, and members who have Medicare Part A are not subject to hospital pre-certification.

Appendix O provides detailed information regarding specific outpatient procedures that must be certified prior to the time rendered. Urgent outpatient procedures performed because of a condition which if not treated within 48 hours would result in significant

deterioration of the member's health status must be certified within thirty calendar days of the date of the procedure.

Failure to obtain the required certification will result in denial of reimbursement.

Rev. Oct. 2014

Procedure for Obtaining Hospital Pre-certification

Pre-certification is required for all inpatient hospital admissions (except for routine procedures performed in an outpatient hospital or ambulatory surgical center setting). Emergent admissions or surgical procedures and all hospital transfers must be certified within thirty calendar days of admission. Certification acknowledges only the medical necessity and appropriateness of the setting and does not guarantee reimbursement.

Requests should be initiated at least one week prior to the planned admission or procedure. Approval is valid for ninety days from the date of issuance. Requests for pre-certifications may be submitted online via the Web portal at www.mmis.georgia.gov.

In accordance with Policies and Procedures for Medicaid Peach Care for Kids Part 1 Manual, Section 202, when an individual is made retroactively eligible, requests for pre-certification must be received within six months from the month of determination of retroactive eligibility. Additionally, when members are eligible for both Medicare and Medicaid, and the Medicare benefits are exhausted, requests for certifications must be received within three months of the month of notification of exhaustion of benefits. For patients later be determined retroactively eligible for Medicaid, DXC Technology must be contacted in advance for a reference number, which will be valid for ninety days. If the patient receives retroactive Medicaid eligibility, providers must continue the pre-certification and prior approval process, providing all required forms and documentation. Please note that obtaining a reference number prior to service provision does not guarantee approval for the requested services as the procedures still will be required to meet medical criteria.

For determining timeliness of pre-certification update requests, if pre-certification has been obtained or is not required for an outpatient procedure, and during the procedure, it is determined that additional or a different procedure is necessary , the additional or different procedure should be considered an urgent procedure. The request for an update of the pre-certification file will be considered timely if received within thirty days of the date of the procedure.

For determining timeliness of pre-certification update requests, if pre-certification has been obtained for an outpatient procedure and after the procedure has been performed, it is determined that inpatient services are necessary , the admission should be considered an emergency. The request for an update of the pre-certification file will be considered timely if received within thirty days of the date of the admission.

804 Procedures for Obtaining Prior Approval for Pharmaceuticals

Rev. Jul. 2012

Approved injectable drugs listed on the Providers Administered Drug List (PADL) do not require pre-certification, unless indicated by the PA symbol. A request for injectable drugs must be submitted via the web portal at www.mmis.georgia.gov. The request must include applicable clinical information and the corresponding ICD-10 diagnosis code, CPT

or HCPCS code 11-digit National Drug Code (NDC) number. Requests that are incomplete may be delayed or denied for insufficient information.

Failure to obtain a prior authorization shall result in denial of reimbursement. Providers should not obtain injectable drugs for administration in the office setting through outpatient pharmacy program and written prescriptions. For information regarding outpatient pharmacy prior approvals refer to the Pharmacy Services manual located at web portal at www.mmis.georgia.gov

Rev. Jan. 2016

805 Prior Approval: Office or Nursing Home Visits

Requests for prior approval for more than ten (10) office or nursing home visits per calendar year for one member may be made if additional visits are medically necessary. Medically necessary visits include life-threatening situations and situations involving serious acute or serious chronic illnesses.

The attending physician must forward a Prior Approval Form DMA-81containing:

A. The member's name and Medicaid number,

B. The diagnoses of the member,

C. Explanation of medical necessity for more than ten (10) visits per year, and

D. The physician's signature (physician's stamps are not acceptable over a typed address).

Approved requests are valid through December 31 of the approval year. The approval form must be retained in the provider's records for the length of time specified in the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.

806 Procedures for Obtaining Pre-certification for Transplants

Requests for approval of coverage of transplants should be submitted online via the web portal at www.mmis.georgia.gov.

Rev Jul 2009

Prior approval and pre-certification accompanied by medical records must be received for review prior to rendering a transplant. Records must be current, and must include medical history, pertinent laboratory findings, x-ray and scan reports, social history and test results that exclude viremia, and justify the medical necessity of the transplant.

Transplant procedures and related services must be approved prior to the time that services are rendered, regardless of age. These services cannot be approved retroactively. The member must be eligible at the time services are provided.

Physician services in connection with the acquisition of tissue or an organ from a living donor for transplant in an eligible member are consider as services for the treatment of the member and are covered a such, although the donor may or may not be Medicaid eligible.

If approval is given for the transplant procedure, a pre-certification number will be assigned.

PART II

CHAPTER 900

SCOPE OF SERVICES

901 General

Federal regulations allow the state agency to place appropriate limits on medical necessity and utilization control. The Division has developed reimbursement limitations to ensure appropriate utilization of funds. These limitations consist of (a) prior approval requirements described in Chapter 800 and in Appendix E, (b) service limitations described in Section 903, (c) service restrictions described in Section 904, (d) non-covered procedures described in Section 905, and (e) eligibility limitations described in Chapter 700.

902 Coding of Claims

Coding of both diagnoses and procedures is required for all claims. The coding schemes acceptable by the Division are the International Classification of Diseases, 10th Revision, Clinical Modification ICD-10-CM for diagnoses and the CPT (Current Procedural Terminology) for procedures.

Division

Not all codes from these coding schemes are accepted by the Division, and certain modifications to the CPT coding scheme have been made. These are discussed in the following Sections.

42 CFR 456.3 requires the Division to "safeguard against unnecessary or inappropriate use of Medicaid services and against excess payments." The Division utilizes a claims adjudication system that encompasses edits and audits to facilitate the Federal mandate. The claims adjudication system's exceptions used are based on nationally accepted standards, including but not limited to the American Medical Association's CPT guidelines, National Correct Coding Initiative (NCCI) edits, Centers for Medicare and Medicaid Services (CMS) standards and publications, and other related medical literature and proprietary software

902.1 ICD-10-CM

Codes deleted from previous editions of the ICD are not accepted by the Division. The provider must select the diagnosis codes from the ICD 10 CM which most nearly describes the diagnosis of the patient.

In coding the diagnosis on your claims, the code must be placed on the claim form using the identical format (including the decimal point) as shown in the ICD 10 CM codes (example: I11, I11.0 and I11.9). Coding must be to the lowest level.

It is the responsibility of the laboratory to obtain the member's diagnosis from the prescribing practitioner at the time the referral is made.

902.2 CPT

The physician must select the procedure code that most closely describes the procedure performed. The following modifications and instructions apply to all physician claims. Professional services should be billed on the Health Insurance Claim Form (Centers for Medicare and Medicaid Services CMS 1500, version 02/12). Refer to Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.

A. Codes deleted from previous editions of the CPT are not reimbursable.

B. Codes for "Unlisted Procedures" are not reimbursable.

C. Modifiers for clarifying circumstances are accepted by the Division, located at the end of this section. All modifiers are subject to post payment review.

Appeals (Electronic Submissions)

Rev Jul 2009

Rev Mar 2018 To check the status of a claim or require assistance with a billing problem, contact the DXC Technology Provider Inquiry line at 1-800-766-4456.

For assistance with resolving denied claims with explanation of benefit (EOB) codes (e.g., timeliness or conflict with another claim and/or payment inquires), submit a completed DMA520 form electronically to DXC Technology at **www.mmis.georgia.gov** within thirty (30) days of the denial. Follow the appeals process and deadlines in Chapter 500, section 502, of the Policies and Procedures for Medicaid Peach Care for Kids Part 1 Manual for additional information.

Rev July 2009 For claims requiring clinical review for medical necessity, submit electronically those requests via the medial review web portal (**www.mmis.georgia.gov**) for medical reviews/provider inquiry form (DMA-520A).

- Once the electronic inquiry is submitted, an inquiry number will be generated. The provider will have the ability to view the medical review decision via the web portal.
- Only one DMA 520A form may be used per inquiry. All data fields must be completed.
- Providers can electronically attach and download the supporting documentation at the time of the inquiry request.
- All provider inquiries and appeals for clinical review and reconsideration that are faxed or mailed (DMA-520A) will not be accepted and will be discarded.
- Mailed DMA-520A provider inquiries and appeals will not be accepted and will be discarded.
- Refer to Chapter 500, section 502, of the Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for additional appeals information.

902.3 General Claims Submission Policy for Ordering, Prescribing, or Referring (OPR) Provider

Rev. Apr. 2014

The Patient Protection and Affordable Care Act (PPACA) requires physicians and other eligible practitioners who order, prescribe, and refer items or services for Medicaid beneficiaries to be enrolled in the Georgia Medicaid Program. CMS expanded the claim editing requirements in § 1833(q) of the Social Security Act and the providers definitions in §1861-r and §1842(b) (18) C to align with the PPACA.

To comply with the PPACA, claims for services that are ordered, prescribed, or referred must indicate the ordering, prescribing, or referring (OPR) practitioner. The Division will utilize an enrolled OPR provider identification number verify Georgia Medicaid enrollment. Any OPR physician, or other eligible practitioner, who are not enrolled in Medicaid as participating (i.e., billing) providers must enroll separately as OPR Providers. The National Provider Identifier (NPI) of the OPR Provider must be included on the claim submitted by the rendering provider. If the NPI of the OPR Provider denoted on the Georgia Medicaid claim is associated with a provider who is not enrolled in the Georgia Medicaid program, the claim will be denied.

Effective 1 April 2014, the Division will check claims for the NPI of all ordering, prescribing, and rendering providers in accordance with the OPR regulation. This edit will be informational until 1 June 2014. Effective 1 June 2014, inclusion of the ordering, prescribing and referring information will become mandatory. Claims that do not contain the required information will be denied.

For CMS-1500 claim form:

Enter qualifiers to indicate if the claim has an ordering, referring, or prescribing provider to the left of the dotted line in box 17 (Ordering = DK; Referring = DN or Supervising = DQ).

For claims entered via the web:

Claims headers were updated to accept ordering or referring Provider ID and name for Dental and Institutional claims and the referring provider's name for Professional claims. The claim detail was updated to accept an ordering or referring provider ID and name. Utilize the "ordering" provider field for claims that require a prescribing physician.

For claims transmitted via EDI:

The 837 D, I, and P companion guides were updated to specifically point out the provider loops that capture the rendering, ordering, prescribing, referring and service facility provider information that is now used to transmit OPR information.

The following resources are available for more information:

- Access the Division's DCH-I newsletter and FAQs at: http://dch.georgia.gov/publications

- Search to see if a provider is enrolled at: https://www.mmis.georgia.gov/portal/default.aspx
    - Choose the 'Provider Enrollment/Provider Contract Status' option. Enter Provider ID or NPI and provider's last name.
- Access a provider listing at: https://www.mmis.georgia.gov/portal/default.aspx

902.4 Accepted Modifiers

22	Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required). This modifier should not be appended to an E/M service.
23	Unusual anesthesia.
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure.
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed.
26	Professional Component: Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.
50	Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50.
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier 52 signifying that the service is reduced.
53	Discontinued procedure.
54	Surgical Care Only: When one physician performs a surgical procedure and another provides preoperative or postoperative management.
55	Postoperative Management Only: When one physician performed the postoperative management and another physician performed the surgical procedure.
56	Preoperative management only.
57	Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E/M service.
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional: During the Postoperative Period: The physician may need to indicate that the performance of a procedure or service during the postoperative period

	was: a) planned prospectively at the time of the original procedure (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier 58 to the staged or related procedure. The modifier is not used to report the treatment of a problem that requires a return to the operating room. See modifier 78.
62	Two Surgeons: When two surgeons work together as primary surgeons performing distinct part(s) of a single reportable procedure, each surgeon should report his/her distinct operative work by adding the modifier 62 to the procedure.
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional.
78	Unplanned Return to the Operating Room by the same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period: Used to indicate that another procedure was performed during the postoperative period of the initial procedure. When this subsequent procedure is related to the first, and requires the use of the operating room, it may be reported by adding the modifier 78 to the related procedure.
79	Unrelated Procedure or Service by the Same Physician by the same Physician or Other Qualified Health Care Professional During the Postoperative Period: The provider may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier 79.
80	Assistant Surgeon: Surgical assistant services may be identified by adding the modifier 80 to the usual procedure number.
AA	Anesthesia services rendered by an Anesthesiologist.
FX	X-Ray taken using film.
GQ	Must be used in conjunction with the appropriate codes for Telemedicine following full implementation of HIPAA compliance (see “Telemedicine Consultations.”)
GT	Must be used in conjunction with the appropriate codes for Telemedicine following full implementation of HIPAA compliance (see “Telemedicine Consultations.”)
QK	Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving a qualified individual, CRNA’s or PAAA’s, by an anesthesiologist.
Q6	Service furnished by Locum Tenens Physicians
QX	Medically directed salaried employee of Anesthesiology.
QY	Medical direction of on anesthesia procedure involving a qualified individual [CRNA’s] or [PAAA’s] by anesthesiologist.
QZ	Non-medically directed, self-employed.
TC	Technical Component: Under certain circumstances, a charge may be made for the technical component alone. Under those circumstances, the technical component charge is identified by adding modifier 'TC' to the usual procedure number. Technical component charges are institutional charges and not billed separately by physicians.
UN	Portable x-ray (two patients served)
UP	Portable x-ray (three patients served)
UQ	Portable x-ray (four patients served)
UR	Portable x-ray (five patients served)
US	Portable x-ray (6 or more patients served)

903 Coding Modification and Service Limitations

The services or groups of services in this Section are covered with limitations. If a physician has medical justification for exceeding a service limitation, the medical justification should be documented and available to the Division upon request. Lack of documentation and justification will be grounds for denial or reduction of reimbursement, or recoupment of reimbursement.

Charts and Records

The physician must maintain legible, accurate, and complete charts and records to support and justify the services provided. A chart is a summary of essential medical information on an individual patient. A record is a date report supporting the claim submitted to the Division for services provided in an office, home, nursing facility, hospital, outpatient, emergency room, or other place of service. A record of service must be entered in chronological order by the practitioner who rendered the service. For reimbursement purposes, such records shall be legible and shall include at a minimum, the following information:

A. Date of service

B. Patient's name and date of birth

C. Name and title of person performing the service

D. Chief complaint or reason for such visit

E. Pertinent medical history

F. Pertinent findings on examination

G. Medications, equipment, or supplies prescribed or provided

H. Description of treatment (when applicable)

I. Recommendations for additional treatment, procedures, or consultations

J. X-rays, tests, and results

K. Plan of treatment, care, and outcome

L. The original handwritten personal signature, initial, or electronic signature of the person performing the service must be on the patient's medical records within three months of the date of service. This includes, but is not limited to, progress notes, radiological, and laboratory reports for each date of services billed to the Division. A signature on the super bill does not satisfy this requirement. Medical record entries without specified signature can result in recoupment of payment.

M. All medical records must be written in Standard English Language. Records must be available to the Division or its agents, and to the U.S. Division of Health and Human Services, upon request. Documentation must be timely, complete, and consistent with the bylaws and medical policies of the office or facility where the service is provided.

903.1 Anesthesia Services

Note: Please refer to Schedule of Maximum Allowable CPT Anesthesia Base Units for further clarification regarding anesthesia services.

903.2 Antigen Therapy

Reimbursement policies for antigen therapy are:

Complete Service Billing

Complete service codes 95120 through 95134 are not reimbursable. The services must be billed using component billing.

Component Service Billing

To bill for the professional service of injecting the antigen, use the most appropriate code (95115 or 95117).

If providing the extract, use the appropriate extract provision code (95145, 95146, 95148, 95149, 95165, or 95170) Allergists who use treatment boards and have used complete service codes in the past must now use component billing as described above.

Code 95144 single dose vial must be used when an allergist is preparing extract to be injected by another physician.

903.3 Auxiliary Personnel

The Division has no provision for direct enrollment of, or payment to auxiliary personnel employed by the physician, such as nurses, non-physician anesthetists, unlicensed surgical assistants, or other aides. Physician's Assistant services are reimbursable only under criteria set forth in subsection 601.11 of the manual.

Certified Pediatric, OB\GYN and Family Nurse Practitioners, and CRNAs are eligible for Georgia Medicaid enrollment. Licensed physical, occupational, and speech pathology therapists are eligible for enrollment to provide services to members less than twenty-one years of age. Services provided by practitioners eligible for enrollment cannot be billed by the physician. Physicians cannot be reimbursed for services provided by physician extenders except for their enrolled physician's assistants.

When the physician employs auxiliary personnel to assist in rendering services to patients and bills the charges as part of the physician's charge for the service, the Division may reimburse the physician for such services if the following criteria are met:

1. The services are rendered in a manner consistent with the requirement of Section 601.1 of this manual.

2. The services provided are "incident to" services performed under the direct supervision of the physician as an adjunct to the physician's personal service.

3. The services are of kinds that are commonly rendered in the particular medical setting.

4. The services are not traditionally reserved to physicians. Services traditionally reserved to physicians include but are not limited to hospital, office, home or nursing home visits; prescribing of medication; psychotherapy; and surgery.

Employed auxiliary personnel performing an 'incident to' services may be part-time or full-time, or leased employees of the enrolled physician. To satisfy the employment requirement, auxiliary personnel must be considered an employee of the enrolled physician and the leased employees must be full-time and the terms of lease must render leased employees in all respects under control and supervision of enrolled physician. To satisfy the employee lease requirement, the applicable agreement, the term of the lease must be for a minimum of one year.

Services provided by auxiliary personnel not employed by the physician are not covered regardless if the services are provided on physician's order.

"Incident to" means the services are provided as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness. Such a service could be considered "incident to" when provided during a course of treatment when the physician performs an initial service and subsequent services of a frequency that reflects the physician's active participation in and management of the course of treatment.

Direct supervision by the physician does not mean the physician must be present in the same room; however, the physician must be present at the site of the services and must be immediately available to provide assistance and direction throughout the time the services are performed.

"Commonly rendered" services are those customarily considered incident to the physician's personal services in the particular medical setting.

Rev. Oct. 2014 **903.4** **Consultations**

A consultation is a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem or to determine whether to accept responsibility for ongoing management of the patient's entire care or for the care of a specific condition or problem.

The Division consultation codes 99251-99255 were reopened for eligible Medicaid members. All hospital consultation visits must be initiated by the initial hospitalist or an initiating provider for another physician of a different specialty to provide a consultation in the hospital. The written request for consultation must be part of the initiating physician's record. The request must require an opinion from the consultation.

Any overuse and misuse of billing hospital initial visit codes 99221-99223 rather than the most appropriate inpatient consultation codes 99251-99255 may result in an internal review by the DCH's Program Integrity Unit/Office of Inspector General or external Recovery Audit Contractor.

If subsequent to the completion of a consultation the consultant assumes responsibility for management of a portion or all of the patient's condition(s), the

appropriate Evaluation and Management services code for the site of service should be reported. In the hospital or nursing facility setting, the consultant should use the appropriate inpatient consultation code for the initial encounter and then subsequent hospital or nursing facility care codes. In the office setting, the consultant should use the appropriate office or other outpatient consultation codes and then the established patient office or other outpatient services codes.

903.5 Co-payment

Rev Sep 2009

See Appendix Q for details.

903.6 Dialysis Services

A. Acute Renal Failure

Dialysis services provided for acute renal failure are reimbursable under the Physician Program using hospital visit codes, critical care codes, or appropriate surgical care codes. CPT dialysis services codes are not covered.

"Acute renal failure" is a condition that is potentially reversible.

Acute Dialysis is not provided to patients because ESRD patients have permanent, not temporary, kidney failure.

B. Chronic Renal Failure

1. Medicaid-Only Members

Dialysis services are available to Medicaid-only members under the Dialysis Services program. All professional and technical services must be billed in compliance with the Dialysis Services manual. Physicians rendering the professional component of the dialysis services must enroll separately in the dialysis program under each facility where they are affiliated. Reimbursement is not available for professional services rendered in a non-enrolled facility.

2. Medicare/Medicaid Members

Medicare is the primary payer for dually eligible members. Medicare reimbursement applies for all dialysis related services. No reimbursement will be made for non-covered Medicare dialysis services.

903.7 Electrocardiograms (EKG)

CPT code 93014 is reimbursable when the physician who is interpreting an EKG performed in a rural area by a physician's assistant or a nurse practitioner, and no physician is immediately available at the rural clinic. The code should not be used to bill for services to a patient who is hospitalized and on a cardiac telemetry monitor. Additionally, the code should not be utilized to report transmissions of patient demand event monitoring devices.

CPT code 93268 should be used to report transmission, physician review, and interpretation of event recordings produced by a cardiac event recorder.

903.8 Family Planning Services

Please refer to the Family Planning Services Manual.

903.9 Hospital Evaluation and Management Services

All levels of hospital evaluation and management (E/M) codes as specified in the current CPT manual, including definitions and instructions are incorporated by reference.

If a member is admitted to the hospital as an inpatient in the course of an appointment in another site of services (e.g., hospital emergency Division, physician's office, nursing facility) all evaluation and management services provided by that physician in conjunction with that admission are considered part of the initial hospital care when performed on the same date as the admission, and should not be billed separately.

Evaluation and management codes associated with surgical procedures are discussed in Section 903.26: Surgery.

A. Daily Hospital E/M Services

1. Initial hospital care using codes 99221 through 99223 is reimbursable only to the admitting physician. Only one unit of any one of these codes is reimbursable per admission.

2. E/M services and psychiatric services rendered on the same date of service by the same provider or provider group must be billed using either 90832 through 90837.

3. Hospital, emergency, observation, NICU, consultations, or critical care E/M Services on the same date of service are not separately reimbursable to the same physician or group of physicians of the same specialty. Only one charge per specialty for the most appropriate level of care may be reimbursed per date of service.

4. Hospital E/M services must be documented in the hospital records on the date of each visit.

5. Documentation of service in the physician's office records is not sufficient for reimbursement of hospital E/M services.

6. Hospital E/M services to members waiting nursing home placement are not reimbursable unless the services are medically necessary.

7. Observation or inpatient hospital care codes 99234 through 99236 must be used for outpatient observation or hospital admission that begin and end on the same calendar date with a minimum of twelve hours.

903.10 Observation

Rev. Jan. 2013

Observation services are services by a hospital/physician, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an out-patient's condition, or to determine the need for a possible admission to the hospital as an inpatient. Such services are covered if provided per physician's order (Observation services usually do not exceed twenty-four hours. Some patients, however, may require 48 hours of outpatient observation services. In only rare and exceptional cases do outpatient observation services spa n more than 48 hours.

A person is considered a hospital inpatient if formally admitted and acute inpatient qualifying criteria designated by Division, such as InterQual7 are met. The purpose of observation is to determine the need for further treatment or for inpatient admission. Thus a patient in observation may improve and be released or admitted as an inpatient.

If a patient is retained on observation status for 48 hours without being admitted as an inpatient, further observation services will be denied as not reasonable and necessary for the diagnosis or treatment of a physical or mental condition. (See section 106, Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.) A maximum of 48 hours of observation may be reimbursed. If the 48-hour observation limit is exceeded and the patient does not meet the criteria for inpatient admission, the submitted claim may include the total number of units, but the facility will only receive reimbursement for the 48 hours or units. However, any services provided beyond the medically necessary time are non-covered.

Observation generally covered as an outpatient service. Observing the patient for up to 24 hours should be adequate in most cases. A physician who believes that exceptional circumstances in a particular case justify approval of more than 48 hours in an outpatient observation setting may submit a claim with documentation of the exceptional circumstances. The claim can be appealed for medical review. If, after medical review, the determination is made that continued observation beyond 48 hours was medically necessary, an observation status may be approved.

Outpatient observation is not covered in the following situations: complex cases requiring inpatient care, post-operative monitoring during the standard recovery period; routine preparation services furnished prior to diagnostic testing in the hospital outpatient Division and the recovery afterwards; and the observation billed concurrently with therapeutic services such as chemotherapy, physical therapy, and similar situations.

The outpatient status becomes inpatient when inpatient services are medically necessary. Inpatient services must be certified per Chapter 800. Certification must be obtained within thirty calendar days of the beginning date of this episode of care. To receive certification for the admission, documentation must be provided proving that the admission is medically and appropriate.

If the provider billed for inpatient services and later determines that the services should have been billed as an outpatient service, the provider has three months from the date of service to adjust the claim. Providers should not substitute outpatient services for medically appropriate inpatient admissions. An inpatient is not considered to have been discharged if placed in observation after an inpatient admission. If an inpatient stay is likely, outpatient observation should not be billed to the Division. The date of the inpatient admission is the calendar date the patient is formally admitted as an inpatient and will count as the first inpatient day.

Elective procedures where the anticipated stay is less than 24 hours is considered an observation stay, if the primary reason for the stay is to monitor for possible complications. Services, such as complex surgery, require inpatient care, and may not be billed as outpatient. Request for updates to the pre-certification file and retroactive certification (except pediatrics as per current policy) of inpatient level of care that should have been anticipated will not be considered timely and will be denied.

The Division covers services that are medically appropriate and necessary. The services provided in the setting must be appropriate to specific medical needs of the member. (See section 106 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.) The medical record must substantiate the medical necessity and appropriateness including appropriateness of the setting. When the outpatient observation setting is non-covered, all services provided in the outpatient observation setting are also non-covered. Services that are not reasonable or necessary for the diagnosis and treatment of patients, but are provided for the convenience of patients or physicians are not covered. (See section 106 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual.)

Level of care and setting determinations are based on patient assessment, medical condition and anticipated or actual treatment as documented in the request for approval. Peer review, in conjunction with inpatient/outpatient qualifying criteria such as InterQual, may be used by PAUM contractors to assess the patient's medical condition and to substantiate medical necessity for inpatient or outpatient status. s. Hospitals are required to conduct concurrent review and to keep the hospitalized patient until the same criteria indicates hospitalization is no longer necessary. The Division will notify providers in writing 30 days prior to the date of any changes in the criteria or version of criteria being used to certify inpatient admissions. Written notice will be provided on banner messages and on remittances. The same version of criteria will be used for any retrospective medical reviews as were used prospectively.

903.11 Providers Administered Drug List (PADL)

Rev. Jul 2012/Oct 2017 Procedure codes and descriptions for injectable drugs (other than allergy injections) are listed in the Providers Administered Drug List (PADL). Unless otherwise specified, immunization drugs for members less than 19 years of age are covered under the Health Check for Kids Program.

Claims for injectable drugs and immunizations must include CPT or HCPCS code and must also have an NDC.

Medications listed in the PADL do not require prior authorization (PA) unless otherwise indicated by PA

Rev July 2009 Effective 1 September 2009, the Division's maximum allowable reimbursement for approved drugs on the Providers Administered Drug List to the lesser of:

A. The provider's usual and customary charge; or,

B. Average Sales Price (ASP) plus 6% as defined July 1st of each year or upon the drug's initial availability in the marketplace, whichever is later; or,

C. Average Wholesale Price (AWP) minus 11% for injectable drugs that do not have ASP pricing, until ASP pricing becomes available and ASP plus 6% pricing can be utilized.

D. Drugs on the PADL that are without an ASP rate are denoted by an inverted triangle **(▼).**

Rev July 2009 Administration fees are not separately reimbursable under the Physician Services Program for injectable drugs with the exception of chemotherapy administration codes 96401-96542 and certain vaccines.

Please refer to the Provider Administered Drug List for additional information.

903.12 Laboratory Procedures

Laboratory procedures are defined in the CPT in the ranges 80300 through 89398 and panels 80047 through 80076. Providers must select the procedure code that most closely describes the procedure performed.

A. Multi-channel Tests

Individual components of automated, multi-channel tests must be billed separately. These tests must be billed using codes in the ranges 80300 through 89398 and panels 80047 through 80076. Only one unit of the appropriate test may be billed for one date of service.

Additional instructions and reimbursement information are located in the Schedule of Maximum Allowable Payments for Clinical Laboratory and Anatomical Pathology Services. This schedule is applicable to laboratory procedures that are performed in a physician's office or in an independent laboratory. The Division has established the following limitations for reimbursement for laboratory services.

1. Physicians billing for laboratory services must be in compliance with the final rules of the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) to receive Medicaid reimbursement. At a minimum, a certificate of waiver is required for tests as defined by the Centers for Medicare and Medicaid Services (CMS). For tests performed of moderate or higher complexity, the physician must meet the CLIA requirements for certification.

2. Providers who do not have a Certificate of Waiver or Registration on file with CMS will have claims denied for laboratory services. If erroneous payment has been made to providers without appropriate certification, the Division will initiate recovery procedures.

3. The Division will not reimburse physicians for laboratory procedures that are sent to state, public, or independent laboratories. Independent laboratories are enrolled separately in the Medicaid program and must bill the Division directly for their services. Reimbursement for the collection and handling code, 99000, and the specimen collection code 36415 is included in the E/M services code reimbursement and is not separately reimbursable. The laboratory procedures shown below must be sent to the appropriate state laboratory with the member's name and Medicaid number for the test procedures to be performed without charge. The following procedures are to be sent to the State Laboratory System

B. Newborn Screens

The following follow up tests are allowed on infants less than three (3) months of age when the initial screenings is positive. These claims must be billed with diagnosis code ICD 10 CM P09. However, the neonatal metabolic screens are required by the State on all infants between 24 hours after birth or by the seventh day of life. The initial screening specimen shall continue to be sent on filter paper (DHR Form 3491) to the Public Health Laboratory, Central Facility in Atlanta only.

Procedure Codes:

82016 82017 82127 82131 82261 84150

82775 82776 83020 83498 83788

84030 84436 84437 84442 84443

Specimens for the above battery of tests may be on a full blood sample (not filter paper) and must be performed by any CLIA certified participating laboratory.

Hemoglobin Testing

The Division will not make payment for the following tests for sickle cell detection, confirmation or follow-up for infants and family members of infants suspected of sickle cell anemia or trait:

CPT 83020 includes SS, SC, SE, S Beta Thalassemia, SO and SD.

All blood specimens with a sickle cell indicator must be forwarded in an appropriate sickle cell outfit to the Waycross Regional Public Health Laboratory.

The Division will provide reimbursement for these hemoglobin tests for possible diagnosis other than sickle cell.

Rev Jan 2016

D. Syphilis Serology

Refer to the Independent Lab Services Manual for a list of covered procedure codes for syphilis testing. The Division will not reimburse for syphilis serology.

E. Tuberculosis Testing

The following procedures are for tuberculosis diagnosis ICD 10 CM A15.0 through A15.9 & A18.4 testing :

87116 and 87118

All sputums with a tuberculosis indicator must be forwarded in the sputum outfit provided by the State to the State laboratory in Atlanta only. Under no condition will the Division reimburse for tuberculosis testing.

F. Salmonella and Shigella Testing

Diagnoses included are ICD 10 CM A02.0 – A03.9.

The procedures are: 87045 and 87081.

Stool culture is often used for the detection of salmonella or shigella. All stool cultures with a salmonella or shigella indicator must be forwarded in a stool culture outfit (provided by the State) to the State laboratory in Atlanta. Under no condition will the Division reimburse for salmonella or shigella testing.

K. HIV/AIDS Test Procedures:

Rev Jan 2016

The Division reimburses for screening tests when ordered by the member's physician or practitioner within the context of a healthcare setting and performed by an eligible Medicaid provider. Please refer to the Independent Lab Services manual for a list of covered procedure codes for HIV testing.

H. Drug Testing

Drug procedures are divided into three subsections: Therapeutic Drug Assay, type of patient results obtained. Therapeutic Drug Assays are performed to monitor clinical response to a known, prescribed medication. The two major categories for drug testing in the Drug Assay subsection are:

1. Presumptive Drug Class procedures are used to identify possible use or non-use of a drug or drug class. A presumptive test many be followed by a definitive test in order to specifically identify drugs or metabolites.

2. Definitive Drug Class procedures are qualitative or quantitative tests to identify possible use or non-use of a drug. These tests identify specific drugs and associated metabolites, if performed. A presumptive test is not required prior to a definitive drug test.

Presumptive Drug Class Screenings are drugs or classes of drugs may be commonly assayed first by presumptive screening method followed by a definitive drug identification method. The list of drug classes and the methodology are considered when coding presumptive procedures. If a drug class is not listed in List A or List B and it is not performed by Thin-Layer Chromatography **(**TLC**),** use 80304 unless the specific analyte is listed in the Chemistry Section.

Definitive Drug Testing

Definitive drug identification methods are able to identify individual drugs and distinguish between structural isomers but not necessarily stereoisomers. Definitive methods include, but are not limited to, gas chromatography with mass spectrometry and liquid chromatography mass spectrometry and exclude immunoassays and enzymatic methods. The Definitive Drug Classes Listing provides the drug classes, their associated CPT codes, and the drugs included in each class. Each category of a drug class, including metabolite(s) if performed (except stereoisomers), is reported once per date of service. Metabolites not listed in the table may be reported using the code for the parent code for the parent drug. Drug class metabolite(s) is listed as a separate category in Definitive Drug Classes Listing.

The code is based on the number of reported analytes and not the capacity of the analysis.

Specimen outfits for testing to be done in the Regional Laboratories should be ordered directly from those laboratories at the below listed address.

The State Laboratory locations and telephone numbers are listed below:

Atlanta Central Laboratory
Georgia Department of Public Health

1749 Clairmont Road
Decatur, Georgia 30033-4050
(404) 327-7900

Waycross Regional Laboratory
Georgia Department of Public Health
1101 Church Street
Waycross, Georgia 31501-3525
(912) 285-6000

903.13 Medicare Deductible/Coinsurance

If a member is eligible for both Medicaid and Medicare, all claims must be sent to the Medicare carrier first. Medicare upper limits of reimbursement will apply for all services covered by Medicare. Policies and procedures for billing these services and detailed coverage limitations are described in Chapter 300 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual and Chapter 1000 of this manual.

903.14 Neurology and Neuromuscular Procedures

Codes for certain neurology and neuromuscular procedures have two billing formats:

A. Professional Component

Charges billed with an inpatient or outpatient hospital place of service are reimbursed for the professional component only. These charges will automatically assign a modifier 26 to the procedure code.

B. Complete Procedure

Codes used for complete procedures performed in the physician's office are identified in the range 95819 through 95999 of the CPT.

903.15 Newborn Care

Reimbursement is available for inpatient post-natal, normal newborn care on eligible newborns. Services including the history and physical, along with the subsequent hospital care and discharge day management are reimbursable for normal newborns when medically necessary. Applicable codes include:

- 99238 (Hospital discharge day management) cannot be billed on the same date as 99461. See Section 903.12 for Neonatal test requirements.
- 99460 History and Examination
- 99462 Subsequent hospital care

Hospital services for all babies must be billed under the baby's Medicaid number and must contain the diagnosis code reflective of the medical condition. Care for infants whose condition requires neonatal intensive care, whether performed in the NICU or another area, must be billed using the NICU codes 99468 and 99469.

Services specified by the CPT as being included in the NICU E/M codes are not separately reimbursable.

Rev Jan 2009

On the day of delivery, in addition to the initial NICU procedure code (99468), the physician can bill for procedure code 99465 (newborn resuscitation) or 99464 (attendance at delivery) if appropriate. (CPT code 99465 can be reimbursed separately on the day of delivery, if the newborn resuscitation occurred prior to admission to the NICU).

Only one initial NICU procedure code 99468 is allowed per hospital admission. Preventative health screening of eligible children performed after the newborn examination is covered under HealthCheck only. See section 701, Appendix D, and the HealthCheck Manual.

Newborn circumcisions and routine newborn care provided in the hospital setting must be billed under the baby's name and Medicaid number.

Please see Section 113.1 of Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for information regarding Medicaid eligibility for newborns.

Newborn Certification Form, See Appendix J

903.16 Non-Invasive Vascular Studies

No reimbursement will be made for the use of a simple hand-held or other Doppler device that does not produce hard copy output, or that produces a record that does not permit analysis of bidirectional flow as this is part of the physical examination of the patient. All procedures are valued based on the assumption that the procedures are bilateral.

903.17 Nursing Home Services

Please refer to the Nursing Facility Manual.

903.18 Obstetrical Services

A. Initial Visit and Prenatal Profile

The Division provides reimbursement for the initial and prenatal visit to determine pregnancy and the initial laboratory services (prenatal profile) separately from any other obstetrical care. Charges for these initial services should be billed immediately after the initial contact.

B. Antepartum, Delivery and Postpartum Care

The Division provides reimbursement for the antepartum and postpartum visits after the determination of pregnancy and the initial laboratory services (prenatal profile) performed separately from any other obstetrical care. Charges for these antepartum and postpartum services should be perform after initial visit.

C. Total Obstetrical Care

If a member is eligible for Medicaid for the entire duration of a pregnancy and is cared for by one practitioner or a group practice, the attending practitioner must bill the Division under the appropriate procedure code for total obstetrical care which includes antepartum care, delivery, and postpartum care.

For reimbursement, the attending physician should be designated in the member's chart and services billed under that practitioner's number.

When a C-section is performed and the attending is not part of a group practice authorized to perform C-sections, the global package cannot be billed. The physician performing the C-section must bill for that service and the attending must bill for the appropriate antepartum and postpartum care.

If an OB patient is admitted for a non-delivery related diagnosis in observation status and at the end of 48 hours admission is required and criteria met, contact DXC Technology for pre-certification.

Antepartum care includes the initial and subsequent history, physical examinations, recording of weight, blood pressures, fetal heart tones, routine chemical urinalysis, and monthly visits up to 28 weeks gestation, biweekly visits to 36 weeks gestation, and weekly visits until delivery. Any other visits or services within this time period should be coded separately.

Delivery services include admission to the hospital, the admission history and physical examination, management of uncomplicated labor, vaginal delivery (with or without episiotomy, with or without forceps), or cesarean delivery.

Medical problems complicating labor and delivery management may require additional resources and should be identified by utilizing the codes in the CPT medicine section in addition to codes for maternity care.

If during the course of delivery the attending physician requires the services of a consulting physician, pre-certification is not required if the consulting physician submits CPT codes for consultation only. However, if the consulting physician assumes care, or provides more services than strict consultation, pre-certification is required and should be obtained from the DXC Technology.

Postpartum care includes hospital and office visits following vaginal or cesarean section delivery. For medical complications of pregnancy (e.g., cardiac problems, neurological problems, diabetes, hypertension, toxemia, hyperemesis, pre-term labor, premature rupture of membranes), see services in the Medicine section of the CPT.

For surgical complications of pregnancy (e.g., appendectomy, hernia, ovarian cyst, bartholin cyst), see services in the surgery section of the CPT.

Total obstetrical care cannot be billed for a delivery of less than 20 weeks gestation (by dates or ultrasound). Procedure code 59025 (non-fetal stress test) cannot be billed for members with a gestation period of less than 34 weeks. A physician may bill one fetal non-stress test in 24 hours for members that are at or

past 34 weeks gestation. If the member is on continuous monitoring, only an initial non-fetal stress test should be required. In a rare instance where more than one non-fetal stress test would be required, while the member is on continuous monitoring, there must be clear documented evidence of medical necessity.

D. Partial Obstetrical Care Due to Member Eligibility

If a member becomes eligible for Medicaid as a result of a live birth, no prenatal services (including laboratory) are reimbursable. If the member was ineligible for the nine-month period preceding delivery, the appropriate delivery only or delivery and postpartum care code must be billed. No charge is reimbursable for hospital admission, history and physical or normal hospital E/M services. Deliveries of less than 20 weeks gestation (by dates or by ultrasound) cannot be billed as a delivery.

E. Partial Obstetrical Care Due to Involvement of More Than One Physician during Pregnancy

1. If a physician provides all or part of the antepartum care but does not perform delivery due to termination of pregnancy by abortion or referral to another physician for delivery, use the appropriate CPT code as explained below.

   - Four to six antepartum care visits that do not include the delivery should be billed using procedure code 59425.
   - Seven or more antepartum care visits that do not include the delivery should be billed using procedure code 59426.
   - E/M codes for antepartum services cannot exceed 3 visits.

Rev 01/24/2108 F. Ultrasound and Amniocentesis

Four medically necessary obstetric ultrasounds shall be allowed per pregnancy. This includes obstetric ultrasounds performed by all providers regardless of place of service. Obstetrical providers shall utilize the following four OB ultrasound procedure codes.

Prior authorization is required after the service has been rendered regardless of the member age or place of service. Reimbursement is limited to services rendered that are medically necessary.

1. 76805 OB US < 14 weeks single fetus
2. 76810 OB US >/ 14 weeks additional fetus
3. 76812 OB US Detailed additional fetus
4. 76817 OB US Transvaginal

a) Out-of-State Deliveries

G. First Trimester Incentive Pay

The Division provides incentive pay if the provider begins routine antepartum care during the first trimester of pregnancy (on or before 14 weeks gestation)

and continues to provide normal prenatal care through the entire antepartum, delivery, and postpartum period.

Voluntary HIV counseling and testing must be offered or provided. Documentation must be included in the medical records. See Appendix S for Provider's Guide to HIV Pre-test and Post-test Counseling. Failure to document may result in recoupment of the entire incentive payment.

To bill for this incentive pay, 22 modifier should be added to either code 59400 Total Obstetrical Care - Vaginal Delivery; 59510 - Total Obstetrical Care - Cesarean delivery; 59610 - Total Obstetrical Care Vaginal Delivery After Previous C-Section; or 59618 - Total Obstetrical Care, C-Section Delivery After Previous C-Sections; as appropriate. Please note that these codes are mutually exclusive and only one can be billed per pregnancy.

H. Early Elective Deliveries

Effective October 1, 2013, the Medicaid Division within the Department of Community Health changed its benefit coverage for non-medically necessary cesarean deliveries prior to 39 weeks gestation. Claims submitted for ANY labor inductions or cesarean sections on or before 39 weeks gestation that are not properly documented as medically necessary will be denied in the Georgia Medicaid Management System (GAMMIS). DXC Technology's current MMIS will be updated later for claims processing of this benefit coverage for early elective deliveries (EED) including non-medically necessary cesarean deliveries and early inductions. This policy was approved as a mandate by the 2013 Georgia legislature in Georgia's SFY 2014 budget bill.

Hospital UB 04 Claims

There are no proposed changes to the current billing process of inpatient claims for induction/delivery services when processed through the claims adjudication process for payment. Hospitals are strongly encouraged to collaborate with their physicians privileged to provide obstetric services in order to develop guidelines and protocols (i.e., a scheduling protocol or Hard Stop Policy and/or establish documentation standards) for deliveries prior to 39 weeks gestation. Hospitals are also encouraged to enforce those guidelines and protocols.

Professional 1500 Claims

Practitioners are to continue billing obstetric procedure codes on their professional 1500 claim forms for payment: 59400, 59409, 59410, 59514, 59510, 59515, 59610, 59612, 59614, 59618, 59620, and 59622, along with one of the three (3) modifiers (UB, UC, or UD) appended to the billed delivery procedure code. GAMMIS will be configured with system edit(s) for the delivery claims that do not append one of the required EED modifier and/or that do not meet the approved guidelines of billing certain clinical indications. Delivery claims that are submitted with medical conditions that do not warrant an exception prior to 39 weeks gestation will post the EED edit requiring medical review by our state's

peer review organization, Alliant Health Solutions (AHS). Clinical justification and the proper documentation must be submitted to Alliant Health Solutionsfor review of the denied obstetric delivery claim. Also, ALL Medicaid practitioners' claims for elective inductions/C-sections must include EITHER the last menstrual period (LMP) or the estimated date of confinement (EDC) or the estimated delivery date (EDD) in field locator 14 of the CMS 1500 paper/electronic form.

Delivery Modifiers for Professional 1500 Claims

One of the following modifiers is required when billing obstetric services for payment:

UB—Medically-necessary delivery prior to 39 weeks of gestation

- For deliveries resulting from members presenting in labor, or at risk of labor, and subsequently delivering before 39 weeks, or
- For inductions or cesarean sections that meet the ACOG or approved medically necessary guidelines, the appropriate ACOG Patient Safety Checklist must be completed and maintained for documentation in the GA enrolled member's file, or
- For inductions or cesarean sections that do not meet the ACOG or approved guidelines, the appropriate ACOG Patient Safety Checklist must be completed. Additionally, the enrolled provider must obtain approval from the state's peer review organization, Alliant Health Solutions, and maintain this checklist in the enrolled member's file. The practitioner must submit to Alliant Health Solutions the clinical justification and documentation for review along with the Patient Safety Checklist.

UC—Delivery at 39 weeks of gestation or later

- For all deliveries at 39 weeks gestation or more regardless of method (induction, cesarean section or spontaneous labor).

UD—Non-medically necessary delivery prior to 39 weeks of gestation (Elective non-medically necessary deliveries less than 39 weeks gestation)

- For deliveries less than 39 weeks gestation that do not meet ACOG or approved guidelines or are not approved by the Georgia Medical Care Foundation as medically necessary with clinical justification. Examples of unacceptable medical reasons include patient choice, physician going out of town, history of a fast labor, etc.

NOTE: Obstetric delivery claims that are submitted without one of the required modifiers listed above will be denied. To avoid claim denials, the two-digit modifier is required whenever billable obstetrical procedure codes are submitted for payment either for vaginal deliveries or cesarean sections.

Documentation Requirements

Providers should utilize medical standards before performing cesarean sections, labor inductions, or any delivery following labor induction. The

documents required for peer review are the member's history and physical, admission notes for the delivery, operative report, if applicable, for cesarean sections, physician progress notes, labor and delivery report, discharge summary, and the ACOG Patient Safety Checklist or an appropriate checklist that meets national guidelines. There are medically necessary conditions that may warrant clinical justification with the proper documentation for an early induction or cesarean section (refer to links in references) for some approved exceptions of medical conditions for deliveries prior to 39 weeks. The list of conditions is not meant to be exclusive.

References

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc005.pdf?dmc=1&ts=20130911T1426455280 (Scheduling Induction of Labor Checklist)

http://www.acog.org/~/media/Patient%20Safety%20Checklists/psc003.pdf?dmc=1&ts=20130911T1426455290 (Scheduling Planned Cesarean Delivery Checklist)

https://manual.jointcommission.org/releases/TJC2013A/AppendixATJC.html#Table_Number_11_07_Conditions_Po (Joint Commission Conditions)

Rev. Apr. 2011 **903.19** **Tobacco Cessation Services for Medicaid Eligible Members**

Effective 1 January 2014, the Division began coverage of tobacco cessation services to all Medicaid members. Medicaid enrolled providers may bill for this service in addition to billing the appropriate Evaluation and Management (E/M) office visit along with CPT codes 99406 or 99407 only. Procedure codes 99406 and 99407 are to be rendered in a face–to-face setting with the member.

Only two 12 week tobacco cessation treatment period will be allowed per member per year. A face-to-face counseling session is required for this service and must be documented in the member's medical record every 30 days during the 12 week treatment period.

Pharmacotherapy medication is also covered. Please refer to the Pharmacy Services Manual for detailed information on the covered medications and prior authorization procedure.

Rev. Jan. 2016 **903.20** **Office or Other Outpatient E/M Services**

All levels of office and other outpatient E/M services as specified in the current CPT manual, including definitions and instructions, are incorporated herein by reference. In addition, the following limitations apply for members aged twenty-one years or older:

A. Reimbursement for office E/M services is limited to ten (10) per member per calendar year, regardless of the number of physicians rendering care, unless prior approval has been obtained, or if the visit is an emergency. (See Chapter 800, section 804 for prior approval procedures.) Claims for emergency office E/M services must be clearly marked "EMERGENCY" and describe the emergent condition. Office records or notes must be submitted with all claims marked "EMERGENCY" to support medical necessity. All emergency claims must be forwarded to:

Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105329
Atlanta, Georgia 30348

B. Please see the Family Planning Manual for reimbursement of Family Planning E/M services.

C. Only one office E/M per date of service is reimbursable to the same provider or provider group regardless of extenuating circumstances except in the case of providers of different specialty codes.

D. Office E/M services rendered after office hours, during night hours, Sundays and holidays, are included in the same maximum allowable as regular office E/M Services.

E. The service was provided in a situation where a delay in treatment would endanger the health of the individual.

Routine health care or elective surgery is not covered unless prior authorization is obtained.

The referring in-state provider is required to request prior approval by documenting medical necessity of obtaining services out of state and providing the name and address of the out-of-state medical provider. Out-of-state providers should submit medical documentation including a care plan and notification of discharge for evaluation of care to the Division's medical peer review contractor, Alliant Health Solutions.

Reimbursement and coverage of out-of-state services is determined in accordance with the Division's current policies and procedures and are contingent on the patient's eligibility at the time services are rendered.

Reimbursement shall be limited to the lesser of the Medicaid reimbursement amount for the state where the service was rendered, or 45% of the billed charges, or the current reimbursement for Georgia Medicaid enrolled physicians, as cited in Section 1001—Reimbursement Methodology.

All services provided to members while out of state by providers not properly enrolled will be subject to prepayment review.

Requests for prior approval or questions regarding out-of-state services must be directed to:

Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105329
Atlanta, Georgia 30348
800-766-4456 (Toll free)

903.21 Out-of-State Services- Non-Enrolled Providers

The Division will pay for medical services for members rendered out of state if the claim is received within twelve months from the month of service and if one or more of the following conditions are met:

A. The service was prior authorized by the Division,

B. The service was provided as a result of an emergency or life-endangering situation (If the out-of-state provider the medical record must supports the existence of an emergency situations but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical records.), or,

C. The service was rendered in a situation when a delay in treatment would endanger the health of the individual.

Routine health care or elective surgery is not covered unless prior authorization is obtained.

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Rev. Oct. 2014

The referring in-state provider is required to request prior approval by documenting in writing the medical necessity of obtaining services out of state and providing the name and address of the out-of-state medical provider. The out-of-state provider is required to submit medical documentation to include a care plan and notification of discharge for evaluation of care to the Division's medical peer review contractor, Alliant Health Solutions.

Reimbursement and coverage of out-of-state services is determined in accordance with the lesser of the following:

- Medicaid reimbursement amount for the state where the service was rendered, or
- 45% of the billed charges, or
- The current reimbursement for Georgia Medicaid enrolled physicians, as cited in Section 1001—Reimbursement Methodology.

All services rendered to members by out of state by providers not properly enrolled will be subject to prepayment review.

Requests for prior approval or questions regarding out-of-state services must be directed to:

Out Out-of-State Processing
DXC Technology/ Alliant Health Solutions Processing – Out of State PA Requests
P.O. Box 105208
Atlanta, Georgia 30348
1-800-766-4456 (Toll free) Customer Service

Alliant Health Solutions fax line: 678-527-3003 (local)
Alliant Health Solutions fax line: 1-877-393-8226 (toll free)

Rev. Jan. 2013 **903.22 Psychiatric Services**

Rev. Oct. 2014 Refer to the Psychology Manual for additional information for services to children under the age of 21 years of age.

Rev Oct 2018, Jan 2019 When billing for psychiatric services, the medical record must indicate the presence or signs of mental illness for which psychological testing is indicated as an aid in diagnosis and therapeutic planning. The medical record must show the test performed, scoring, and interpretation and the time involved.

Covered Services

Effective January 1,2019, Georgia Medicaid has expanded its list of Psychological/Neuropsychological services, which are limited to those services personally provided by the enrolled physician. Adaptive Behavior Assessments and Psychological/Neuropsychological Testing services that span more than eight hours per date of service are subject to review.

Limitations as documented in the Psychology Manual apply regardless of previous physician treatment. Physicians should coordinate all aspects of care. Individual psychotherapy codes should only be used when treatment involves individual psychotherapy. These codes should not be used as generic psychiatric service codes when other codes (e.g., Evaluation and Management codes) would be more appropriate.

Adaptive Behavior Assessments and Psychological/Neuropsychological services are allowable only for members receiving psychology and psychiatry, counseling and therapy services, the member's medical record must indicate the presence or signs of mental illness for which psychological testing is indicated as an aid in diagnosis and therapeutic planning.

In order, for the provider to receive reimbursement for Adaptive Behavior Assessments and Psychological/Neuropsychological Testing services, providers must report the following codes:

96105: Assessment of Aphasia

96125: Cognitive testing

96112: Developmental test administration

96113: Developmental test administration (each additional 30 minutes)

96116: Neurobehavioral status examination

96121: Neurobehavioral status examination (each additional 1 hour)

96130: Psychological testing evaluation

96131: Psychological testing evaluation (each additional 1 hour)

96132: Neuropsychological testing evaluation

96133: Neuropsychological testing evaluation (each additional 1 hour)

96136: Psychological or neuropsychological test administration

96137: Psychological or neuropsychological test administration (each additional 30 minutes)

96138: Psychological or neuropsychological test administration, two or more tests.

96139: Psychological or neuropsychological test administration, two or more tests (each additional 30 minutes)

96146: Psychological or neuropsychological automated testing

97151: Behavior identification assessment

97152: Behavior identification – supporting assessment

97153: Adaptive behavior treatment by protocol

97154: Group adaptive behavior treatment

97155: Adaptive behavior treatment with protocol modification

97156: Family adaptive behavior treatment guidance

97157: Multiple family group adaptive behavior treatment guidance

97158: Group adaptive behavior treatment with protocol modification

90791: Psychiatric diagnostic evaluation

Maximum of 1 per member per 3 calendar years.

Rev Oct 2017 **90792**: Psychiatric diagnostic evaluation with medical services.

Maximum of 24 units within one calendar year.

90870: Electroconvulsive therapy (includes necessary monitoring) 1 per day.

Documentation Requirements

Documentation of the patient's capacity to participate in and to benefit from the therapy must be kept. The type of treatment must be documented in the patient medical records for each service rendered.

Rev. Apr. 2010

- An explanation of why the rendered therapy is the appropriate treatment must be documented.

Rev. Sept. 2010

- The estimated duration of treatment, in terms of number of sessions should be specified.

Rev. Oct. 2012

- For an acute problem, documentation must be included in the medical record that the treatment is expected to improve the health status or functioning of the patient.

- For chronic problems, documentation must be included in the medical record indicating that stabilization or maintenance of health status or function is expected.

- The medical record should document the target symptoms, the goals of therapy, and the methods of monitoring outcomes

Limitations

1. Reimbursement for psychotherapy (90847 and 90853) is limited to a maximum of twelve hours per member per calendar year. Only one hour per date of service can be billed. Services in excess of this limitation may be available through local community mental health programs.
2. Reimbursement for electroconvulsive therapy is limited to twelve treatments per member per calendar year.
3. Reimbursement for family therapy service (90847) is limited to one Medicaid ID number, regardless of the number of covered family members participating in the family therapy session.
4. If medical rounds are made and no psychotherapy is performed, the psychiatrist may bill the most appropriate evaluation and management code.
5. Psychiatrists are limited to the supervision of no more than three qualified salaried employees.

Non-Covered Services

No reimbursement will be made for any type of psychiatric, psychological, family therapy, group therapy, or somatotherapy services provided by other health care

professionals, including but not limited to medical social workers, psychiatric nurses, physician assistants, or other physician extenders.

No reimbursement will be made for any type of psychiatric services provided to patients enrolled in the Therapeutic Residential Treatment program (see section 601.14 for additional information). See section 905 for additional information on non-covered services.

903.23 Radiological Services

Codes for radiological services have three formats: professional component, technical component, and complete procedure. Not all procedures have all three components. In general, these components should be used as follows:

A. Professional Component: (26 modifier)

Radiology services should be billed as professional component when:

1. The physician provides only the professional service for the procedure; or
2. The service is provided in a hospital; or
3. The technical portion of the service is performed by someone other than the physician's salaried employee.

B. Technical Component: (TC modifier)

Radiology services should be billed as technical component when the physician is providing the technical portion of the service only. This component has very limited application under current Medicaid policy.

C. Radiology Component (FX modifier)

D. Complete Procedure

To bill for complete radiological procedures, which include charges for actually processing and developing the x-ray (technical component), and evaluating the x-ray (professional component), submit the codes as defined in the CPT without a modifier.

The physician may bill for complete procedure when one of the conditions outlined in Section 601.5 is met.

When billing for multiple identical radiology services performed on the same date of service, charges must be placed on only one line of the claim form

with the number of X-rays taken being placed in the “unit” space. To bill for identical bilateral procedures where there is not an all-inclusive code bill the procedure code with a 50 modifier’ on one line indicating one unit of service. Use of the 50 modifier will ensure correct payment for both procedures using the one code. However, if there is an all-inclusive procedure code for a bilateral procedure, the all-inclusive charge for the procedure will be reimbursed at the lower of 100% of the allowed amount or the submitted charge.

E. Computerized Tomography - (CAT SCANS)

The Division reimburses for medically necessary CAT scans.

F. Low Osmolar Contrast Media

Payment will be made for medically necessary low osmola (non-trast material (LOCM) used in conjunction with intrathecal, intra-arterial, and intravenous radiological procedures when provided for non-hospital patients. The physician’s medical records must support the medical necessity of low osmolar contrast material.

The following procedure codes must be used when billing for Low Osmolar Contrast Media:

- Q9960 High Osmolar Contrast Material, 200-249 mg/ml Iodine Concentrate, per ml (replacement for A4645).
- Q9961 High Osmolar Contrast Material, 250-299 mg/ml, Iodine Contrast, per ml (replacement for A4645).
- Q9962 High Osmolar Contrast Material, 300-349 mg/ml, Iodine Concentration, per ml (replacement for A4646).
- Q9963 High Osmolar Contrast Material, 350-399 mg/ml, Iodine Contrast Material Concentration, per ml (replacement for A4646).
- Q9965 Low Osmolar Contrast Material, 100-199 MG/ML Iodine Concentration, per ML (replaces Q9946*)*

G. Magnetic Resonance Imaging (MRI)

Medically necessary MRI is covered by the Division when CT scans or SPECT procedures are not definitive or appropriate. Only one MRI per day will be paid without submission of documentation for medical necessity. Reimbursement for follow-up visits by the radiologist is included in the reimbursement for the MRI. Please note that only enrolled Medicaid providers may be reimbursed for MRI procedures.

CT Scans or MRIs that do not require contrast, or are of a lower acuity, may be done under the general supervision of the physician. CT Scans and MRIs

that require contrast, or are at an increased level of acuity, must be performed under the direct supervision of the physician.

Rev Jan 2018 H. Portable X-Ray and CT Scan

Effective July 1, 2017, the Department of Community Health enacted a new policy for medically necessary portable radiological and CT scan services to GA Medicaid eligible members who are unable to travel to radiological facilities. These services are only considered for payment when they are medically necessary and ordered by the member's physician.

The portable radiologic services will serve GA Medicaid members receiving home community based services, skilled nursing facility services, home health, hospice services (POS 31,32 or 33) and eligible member's home (POS 12). The portable x-ray and CT scan services are only considered for payment when they are medically necessary and ordered by the member's primary care physician.

Transportation of portable x-ray equipment is reimbursable only when the equipment used is actually transported to the location where portable x-ray and CT scan services are provided. GA Medicaid will not reimburse for the transportation of the portable x-ray equipment when the x-ray equipment is stored at a facility for use as needed.

GA Medicaid will only pay for single transportation payments per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location. If more than one member at the same location is x-rayed, the portable X-ray transportation fee is allocated among the members who receive portable X-ray services in a single trip.

GA Medicaid reimburses procedure code R0075 (Transportation of portable X-ray equipment), per trip to facility or location for portable X-ray providers, more than one member seen. The Division also reimburse procedure code R0070 (Transportation of portable X-ray equipment), per trip to facility or location, one member seen.

When submitting a claim for procedure code R0075, the provider is required to use a modifier to indicate the total number of Medicaid members served at the location. The provider is required to submit a separate claim for each Medicaid member. A claim with procedure code R0075 will be denied if it is submitted without an appropriate modifier. Each claim for a single location and date of service must indicate the same x-ray transportation procedure code and modifier for all members seen during that visit.

- R0070 Portable x-ray equipment and personnel to the member's home or nursing home, per trip to a facility or other location.

- R0075 Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one member seen, per trip to facility or location. The following modifiers are to be billed with R0075:

  Modifiers:

  (no modifier if one patient served)
  UN - Two patients served
  UP - Three patients served
  UQ - Four patients served
  UR - Five Patients served
  US - Six or more patients served

The physician order must be written and ordered by the member's primary care physician before any portable x-rays and /or CT scan services are provided. The claim for reimbursement must indicate the name of the physician who ordered the service before payment may be made. The submitted claim with place of service in a facility, facility and provider National Provider Identifier (NPI) is required.

Portable X-ray services may be provided to a member in his or her place of residence. The member place of residence is defined by the Division of Medicaid as the member's own dwelling, a residential care facility or nursing facility. Portable X-ray services are not covered in hospital settings.

Note: GA Medicaid will only pay for a single transportation payment per trip to a facility or location for a single date of service. Therefore, providers should make every effort to schedule all members at a single location during a single trip to that location.

All providers, including their staff, contracted staff and volunteers must comply with the Health Insurance Portability and Accountability Act (HIPAA) privacy requirements.

The portable x-ray provider is responsible for determining that a member is Medicaid eligible on the date of service.

Portable x-ray providers must keep the following records for each member for a period of at least 7 years:

- A copy of the written, signed and dated order by the member's physician
- The date of the x-ray examination
- The name of the physician who performed the professional interpretation of the procedure
- The date the radiograph was sent to the physician

Portable x-ray providers will not be reimbursed for the following services:

- Procedures involving fluoroscopy
- Procedures involving the use of contrast media
- Procedures requiring the administration of a substance to the member the injection of a substance, or the spinal manipulation of the member
- Procedures requiring special technical competency and/or special equipment or materials
- Routine screening procedures such as annual physicals
- Procedures which are not of a diagnostic nature, e.g., therapeutic x-ray treatments
- Set-up component (Level II HCPCS code Q0092) non-covered
- Portable X-ray services are not covered in hospital settings
- Annual x-rays

Fee Schedule

Information regarding the Fee Schedule to be used for Portable X-rays and CT Scan can be obtained on www.mmis.georgia.gov following the links under “Provider Manual”, “Provider Information”, and “Fee Schedules.”

I. Mammography

All mammograms must be performed at a state certified center, and the results must be interpreted by a physician certified by the American Board of Radiology, or the American Osteopathic Board of Radiology, or certified as qualified to interpret the results of mammograms as determined by the Secretary of Health and Human Services. Contact the office below with questions on obtaining certification.

Office of Regulatory Services
Health Care Services
Georgia Department of Community Health
2 Peachtree Street, N.W., 19th Floor
Atlanta, Georgia 30303
(404) 657-5407

The Division must have an update and valid copy of your certification. Please fax new certification to DXC Technology at 1-866-483-1044 or 1-866-483-1045 or forward to:

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Prior Authorization & Pre-Certification
Alliant Health Solutions
PO Box 105329
Atlanta, Georgia 30348
800-766-4456 (Toll free)

When billing for mammography on the CMS 1500 claim form, enter the radiology center's 6 digits certification number on field 24a, with the preceding EW qualifier. Please refer to Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual for billing instructions.

903.24 Reduced Services (52 Modifier)

Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's election. Use of the 52 modifier signifies that service rendered has been reduced. Reimbursement will be reduced accordingly. Example: When the CPT states that all codes in a section are for a bilateral procedure, the 52 modifiers must be used to report the service if only a unilateral service was provided. Please see the current CPT manual for specific instructions on use of this modifier with specific codes. Failure to use the 52 modifier appropriately will result in recoupment of payment.

903.25 Site of Service Differential

Services that are primarily performed in office settings will be subject to a reduction in reimbursement when performed in an inpatient, outpatient, emergency, or ambulatory surgery setting. The reduced reimbursement is calculated as part of RBRVs and is updated annually. Please see Appendix K for services that are subject to the reduced reimbursement.

903.26 Supplies and Materials

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Office medical supplies, except for drugs and certain supplies associated with performing the procedures shall be considered practice expenses which are included in the payment for the service to which they are incidental. No additional reimbursement will be made.

903.27 Surgery

Foot care for members twenty-one years of age and older is limited to essential care, including but not restricted to, treatment for trauma or complications related to a chronic disease, such as diabetes.

Elective surgeries for members twenty-one years of age and older for correction of conditions that have little or no substantial effect on the health status of the individual are not covered. Decisions on the urgent status of these conditions will be made by the Division's medical peer review contractor.

Reimbursement for surgical procedures is based on the global fee where a single fee is billed, and reimbursement includes all necessary services normally furnished by the surgeon before, during, and after the procedure. Four modifiers

(24, 25, 78, and 79) identify a service or procedure furnished during a global period that is not normally a part of the global fee.

A. Major Surgery

The initial evaluation or consultation by the surgeon will be paid separately from the global surgery package. The pre-operative period will include all pre-operative visits, in or out of the hospital, by the surgeon beginning the day before the surgery.

Modifier QI has been deleted and replaced with modifier 57. Modifier 57 is to be used with the evaluation and management code for the visit or consultation the day prior or the day the decision for surgery is made. Modifier 57 cannot be used with minor surgeries.

The global surgery fee includes all additional medical or surgical care required of the surgeon because of complications that do not require additional trips to the operating room. All medically necessary return trips to the operating room, for any reason and without regard to "fault," shall be separately billed and paid at a reduced rate.

The payment level for re-operations to deal with complications shall be set at the value of the intra-operative services being performed if there is a CPT code to describe these services. If no CPT code exists, the payment level may not exceed 50 percent of the value of the intra-operative services originally performed. (See also description of CPT modifier 78.)

A standard 90-day post-operative period includes all services rendered by the surgeon during this period, unless the service is for a problem unrelated to the diagnosis for which the surgery was performed, or, is for an added course of treatment other than normal recovery from the surgery. (See also description of CPT modifiers 24 and 79.) Immunosuppressive therapy following transplant surgery is not included in the global fee and will be paid separately. The global fee includes services such as dressing changes, local incisional care and removal of operative packs; removal of cutaneous sutures, staples, lines, wires, tubes, drains, casts, and splints; insertion, irrigation, and removal of urinary catheters, routine peripheral intravenous lines, and nasogastric and rectal tubes; and change and removal of tracheostomy tubes.

90-Day Post-Operative Period, (major procedures)

- One day pre-operative included
- Day of the procedure is generally not payable as a separate service
- Total global period is 92 days. Count 1 day before the day of the surgery, the day of surgery, and the 90 days immediately following the day of surgery.

Rev. Oct. 2014

Procedures with a 90-day post-operative follow-up period which are incident to major global surgery policy are listed at CMS Cahaba, located at www.cahabagba.com.

B. Minor Surgery and Non-incisional Procedures

Minor surgeries and endoscopic procedures, no payment generally will be made for a visit on the same day in addition to the surgical procedure or endoscopy procedure identifiable service is furnished (see also description of CPT modifier 25). For example, a visit could properly be billed in addition to payment for suturing a scalp wound if a full neurological examination is made for a patient with head trauma. Billing for a visit is not appropriate if the evaluation consists solely of identifying the need for sutures and or confirming allergy and immunization status.

There is no post-operative period for endoscopic procedures performed through an existing body orifice. Procedures requiring an incision for insertion of a scope (e.g., a laparoscopic cholecystectomy) will be subject to either the major or minor surgical policy, whichever is appropriate.

Rev. July 2016

Minor surgeries have post-operative periods of 0 days or of 10 days. Reimbursement for surgeries with 10 day post-operative period includes all post-operative services related to recovery from the surgery. Services rendered during the 10 day recovery period for treatment of the underlying condition will be paid for separately (see also description of CPT modifier 24). Minor surgeries with a10-day post-operative period are listed in the current “CMS Cahaba Register.”

Zero Day Post-Operative Period (endoscopies and some minor procedures).

- No pre-operative period
- No post-operative days
- Visit on day of procedure is generally not payable as a separate service

10-Day Post-Operative Period, (other minor procedures).

- No pre-operative period
- Visit on day of the procedure is generally not payable as a separate service
- Total global period is 11 days. Count the day of the surgery and 10 days following the day of the surgery.

C. Bilateral Procedures (Modifier 50)

If identical bilateral procedures are performed at the same operative session, the first will be reimbursed at the lower of 100% of the allowed amount or the submitted charge, while the second will be reimbursed at the lessor of 50% of the allowed amount, or at the submitted charge. To bill for identical bilateral procedures where there is not an all-inclusive code, bill the procedure code with a “50” modifier on one line indicating one unit of service. Use of the “50” modifier will ensure correct payment for both procedures using the one code. However, if an all-inclusive procedure code for a bilateral procedure exists, the all-inclusive charge for the procedure will be reimbursed.

D. Multiple Procedures

If multiple surgical procedures add significant time or complexity to the surgery during the same operative session, each clearly identified and defined procedure shall be reimbursed according to the following:

1. The first or major procedure: the lesser of 100% of the maximum allowed amount or of the submitted charge.
2. The second procedure through the fifth procedures: the lesser of 50% of the maximum allowed amount or of the submitted charge.
3. The subsequent procedures: the lesser of 25% of the maximum allowed amount or of the submitted charge.

Each individual surgical procedure for which reimbursement is being requested must be identified on separate lines on the claim form with an associated charge for each procedure. For the reimbursement methodology to accurately applied, separate procedures must be arranged in the order from major to minor on the CMS 1500 claim form, on field 24.

E. Incidental Procedures

Additional charges for incidental procedures performed while other services are rendered are not covered unless substantiated by medical documentation. Examples of such incidental procedures include an incidental appendectomy, incidental excision of scars, and lysis of adhesions. A diseased appendix surgically removed at the same time as another surgery will be reimbursed under the multiple surgery reimbursement policy. Evaluation and Management codes billed with minor procedure codes require medical documentation.

F. Surgical Team

Surgical services furnished by several physicians are reimbursed as if only one physician furnished all of the services in the global package, and the multiple surgery regulations also apply.

G. Co-Surgeons - (Modifier 62)

Co-surgeons will be reimbursed one-half of 125% of the global fee.. Here, no payment will be made for an assistant-at-surgery.

H. Surgical Assistant - (Modifier 80)

The upper limit of reimbursement for the assistant surgeon is 16% of the maximum allowable for the surgical procedure. The services of an assistant surgeon are not reimbursed for non-critical surgical procedures including but not limited to routine appendectomy, herniorrhaphy, or sterilization.

Reimbursement will not be made for an assistant-at-surgery when:

1. The specified surgery does not meet the guidelines for use of an assistant,

2. A resident was available to assist, or

3. An assistant at surgery was not medically necessary.

Claims for appropriate assistant surgeon charges must be billed by the enrolled physician who is performing at the surgery. The “type of service” code “8” - “Assistant at Surgery” must be placed on the claim form and the “80” modifier must be added to the procedure code.

The Division provides reimbursement for an assistant surgeon (modifier 80) according to guidelines set forth by the American College of Surgeons. The procedure codes billed must be the same as procedures codes billed by the primary surgeon.

If the surgeon is assisted by a physician’s assistant whose supervising physician is not enrolled with the Division for PA services, or a non-physician who is not separately enrolled as a certified Nurse Midwife or an Advanced Certified Nurse Practitioner, the charge for such service is not separately reimbursable but are be included in the surgeon’s fee for the procedure.

I. Surgery and Follow-up Care Provided by Different Physicians (Modifiers 54 and 55)

The total amount of all reimbursements for all practitioners who render parts of the services included in a global fee (and who bill using one of the modifiers 54 and 55) shall not exceed the total amount of the reimbursement that would have been paid to a single practitioner under the global fee for the procedure. Each physician will be paid directly for the portion of the global surgery services rendered, providing all parties utilize the appropriate modifiers. The surgeon renders the usual and necessary pre- and intra-operative services, and, with few exceptions, the in-hospital post-operative services. When the surgeon transfers the outpatient recovery care to another health care provider, reimbursement will be adjusted in accordance

with the weighted percentages for post-operative care as published in the November 25, 1991 Federal Register.

By referring a patient to another health care provider, the surgeon agrees to accept the reduced reimbursement for the surgery. The surgeon must file the surgical procedure code with the 54 modifier. The follow-up care cannot be reimbursed until the surgery has been paid. The provider rendering the follow-up care must bill the surgery procedure code once using the 55 modifier. If the surgery is not covered for any reason, the follow-up care is also not covered.

Follow-up care must be completed (either 10 or 90 day global period) before the service is billed. The surgical code used by the operating physician with a modifier of 55 must be billed. Individual office visits are not reimbursable for follow-up surgical care.

J. Ambulatory Surgical Center Services

Certified freestanding ambulatory surgery centers are eligible to enroll in the Division's Ambulatory Surgical Center (ASC) Program. ASCs are limited to providing surgical procedures that would otherwise be covered if performed in a hospital. Selected surgical procedures performed in an ASC setting may require preadmission certification or prior approval. The precertification or prior approval information must be obtained by the physician and given to the ASC prior to the performance of the surgical procedure. Physicians should contact local ASCs to obtain information regarding coverage and policies prior to scheduling surgical procedures.

Failure to use the 54 modifier on the claim prevents payment to the provider rendering post-operative care. Please refer to the Ambulatory Surgery Manual for additional information.

903.28 Telemedicine Consultation

See Appendix R and the Telemedicine for additional information.

903.29 Therapy Service

Therapy services provided to members over the age of 21 are not covered under the physician services program. If the therapy services are part of the member's inpatient admission under precertification requirements and are determined to be medically necessary, the therapy service may be covered under the Hospital Services program (e.g., therapy services after a mastectomy).Therapy services are covered for members under 21 years of age. Please refer to the Children's Intervention Services (CIS) manual.

903.30 Children's Intervention Services

The CIS program is comprised of six intervention services that must be provided by licensed and enrolled practitioners, for members less than twenty-one years of age. The six services are: audiology, nursing, occupational therapy, physical therapy, counseling provided by licensed clinical social workers, and speech-language pathology. Qualified providers must be currently licensed as audiologists, clinical social workers, occupational therapists, physical therapists, registered nurses, or speech-language pathologists. Services provided though the CIS program must be billed under the provider number of the enrolled professional personally performing the service. Please refer to the CIS manual.

903.31 Transplant Services

Covered transplant services, including organ harvesting, may be billed to the Division if the individual receiving the transplant is eligible for Georgia Medicaid and is not eligible for Medicare services. For kidney transplant services, a copy of the Medicare letter denying the Georgia Medicaid member enrollment in the Medicare program must be submitted with the claim. Claims for members eligible to enroll in Medicare for kidney transplant services will not be reimbursed. For further information on transplant services, contact DXC Technology at 1-800-942-4623.

903.32 Vaccines for Children Program (VFC)

Rev. Jan. 2010

Effective 1 October 1994, vaccines given to Medicaid eligible children will be covered only in accordance with the Omnibus Budget Reconciliation Act of 1993 (OBRA '93). Certain immunization drugs for members 19-21 years of age are covered under the Physician Services Program. For further clarification regarding specific CPT immunization codes covered under the Health Check program, in conjunction with Vaccines for Children (VFC), refer to the Health Check Services Manual Appendix E, and the Physician Services Manual, Appendix B and B1.

Administration:

Reimbursement for immunization drugs supplied by VFC and administered to children ages birth to 18 years of age, under the Health Check Program is not covered. Reimbursement is limited to the administration of the vaccine only**.**

Rev July 2009

903.33 Vision Care Service

Refractive services are available to members under the age of twenty-one. All refractive services must be billed on the CMS 1500 claim form and in compliance with the Policies and Procedures for Vision Care Services. Ophthalmologists who render refractive services must enroll in both the Physician Services and in Vision Care Services programs.

Rev. Apr. 2011

903.34 Durable Medical Equipment (DME)

In accordance with the Patient Protection and Affordable Care Act §6407, a face-to-face encounter with patients is required before physicians may certify eligibility for durable medical equipment (DME). Providers who are ordering, prescribing, or rendering, in any other manner supplying durable medical equipment, must comply with the Division's policy and documentation requirements for face-to-face encounters for initial and replacement durable medical equipment, supplies, and modifications. For additional information, refer to the Durable Medical Equipment manual.

904.0 Service Restrictions

904.1 Sterilizations and Hysterectomies

In compliance with 42 CFR 441.250, the Division may reimburse for sterilizations and hysterectomies only if the following requirements are met:

A. Sterilizations

1. The individual is at least twenty-one years old when consent for sterilization is obtained;
2. The individual is not mentally incompetent;
3. The individual voluntarily gave informed consent in accordance with the provisions of this section, and a properly executed "Informed Consent for Voluntary Sterilization" form (DMA-69) is submitted with the claim;
4. At least 30 days, but not more than 180 days, have passed between the date of informed consent and the date of the sterilization, except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery, if the premature delivery occurs before 37 weeks of gestation per the ACOG guidelines, or emergency abdominal surgery if at least seventy-two hours have passed since informed consent for the sterilization was given. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery. The expected date of delivery must be provided on the DMA-69 form;
5. Interpreters must be provided when language barriers exist; and arrangements must be made to communicate the required information to an individual who is blind, deaf, or otherwise handicapped; and,
6. The individual was not institutionalized in a correctional facility, mental hospital, or other rehabilitative facility.
7. The Division cannot reimburse for sterilization, hysterectomies, or abortions without documentation required in 42 CFR 441.206 and 42 CFR 441.256. The Division does not accept documentation for informed consent completed or altered after the service was rendered.

B. Hysterectomies

1. The hysterectomy must have been rendered for medical necessity, and not for the purpose of family planning, sterilization, hygiene, or mental retardation;
2. The individual is informed prior to the hysterectomy that she will be permanently incapable of reproducing (this does not apply if the individual was sterile prior to the hysterectomy, or in the case of an emergency hysterectomy);
3. The individual and the attending physician sign the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" form DMA-276 (6/84) either before or after the surgery is performed (the individual is not required to sign in the cases of prior sterility or emergency hysterectomy); and
4. The properly executed "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" is attached to the claim form submitted to the Division.
5. The Division and the Medicaid program cannot reimburse for sterilization, hysterectomies, or abortions without documentation required in 42 CFR 441.206 and 42 CFR 441.256. The Division does not accept documentation for informed consent completed or altered after the service was rendered.

904.2 Abortions

In accordance with federal regulations and a recent congressionally enacted revision to the Hyde Amendment, the Division will reimburse for abortions performed on Medicaid-eligible patients only if the life of the mother would be endangered if the fetus were carried to term, or if the mother was a victim of rape or incest.

A "Certification of Necessity for Abortion" (Form DMA-311) certifying the above must be properly executed and attached to the claim form when submitted to the Division. Form DMA-311 applies to surgical and non-surgical abortion procedures, such as the use of mifepristone 200 mg (RU486), when used for abortion purposes. In compliance with 42 CFR 441.206, this documentation is required for "any expenditures for abortions or other medical procedures otherwise provided for under Sec. 441.203...," which will include associated services such as lab tests or ultrasound studies.

904.3 Supply of Forms

A supply of the "Informed Consent for Voluntary Sterilization" (DMA-69), the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (DMA-276), the "Certification of Necessity for Abortion" (DMA-311) and "Prior Approval for Medical Services" (DMA-81) forms may be obtained from the Division's fiscal agent at www.mmis.georgia.gov/portal. These forms are the only forms accepted by the Division for the reimbursement of sterilizations, hysterectomies, abortions, and prior approved medical services.

The Division and the Medicaid program cannot reimburse for sterilization, hysterectomies, or abortions without documentation required in 42 CFR 441.206 and 42 CFR 441.256. The Division does not accept documentation for informed consent completed or altered after the service was rendered.

904.4 Colorectal Cancer Screening

The Division will cover colorectal cancer screening tests or procedures for early detection of colorectal cancer. Coverage of the colorectal cancer-screening test includes the following procedures:

1. Screening fecal-occult blood test,
2. Screening flexible sigmoidoscopy,
3. Screening colonoscopy for high risk individuals and
4. Screening barium enema as an alternative to a screening flexible sigmoidoscopy or screening colonoscopy.

The following HCPCS and CPT codes have been established for these services:

G0104 – Colorectal cancer screening; flexible sigmoidoscopy

G0105 – Colorectal cancer screening; colonoscopy on an individual at high risk

Rev. Jan. 2010

G0106 Colorectal cancer screening; barium enema as an alternative to G0104, screening sigmoidoscopy

G0120 – Colorectal cancer screening; as an alternative to G0105, screening colonoscopy

82270 – Blood, occult, by peroxidase activity (e.g., guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (i.e., patient was provided 3 cards or single triple card for consecutive collection)

Limitations:

Screening flexible sigmoidoscopies (G0104) are covered once every 48 months for members 50 years of age and older. If during the course of this procedure a lesion or growth is detected that results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a flexible sigmoidoscopy with biopsy or removal should be billed, not G0104. This screening must be performed by a doctor of medicine or osteopathy.

Screening colonoscopies (G0105) are covered at a frequency of every 24 months for members at high risk for colorectal cancer. If during the course of this procedure a lesion or growth is detected which results in a biopsy or removal of the growth, the appropriate diagnostic procedure classified as a colonoscopy with biopsy or removal should be billed, not G0105. A doctor of medicine or osteopathy must perform this screening.

High risk for colorectal cancer means an individual has one or more of the following:

- A close relative (sibling, parent, or child) who has had colorectal cancer or an adenomatous polyposis;
- A family history of familial adenomatous polyposis;
- A family history of hereditary non polyposis colorectal cancer;
- A personal history of adenomatous polyps;
- A personal history of colorectal cancer; or
- Inflammatory bowel disease, including Crohn's Disease, and Ulcerative Colitis.

Screening barium enema examinations (G0106 and G0120) are covered as an alternative to either a screening sigmoidoscopy or a screening colonoscopy. The same frequency parameters specified for screening sigmoidoscopy and colonoscopy applies.

Screening fecal-occult blood test is covered once every 12 months for members 50 years of age and older.

905 Non-Covered Services

The services and procedures listed below are not covered by the Division under the Physician Program. This list is representative of services and procedures that are not covered, and is not meant to be exhaustive:

A. Cosmetic surgery or mammoplasties for aesthetic purposes.
B. Therapeutic injections except those contained in the Physicians Injectable Drug List.
C. Acupuncture.
D. Biofeedback, hypnotherapy, sleep therapy, and all services listed in the CPT under "Other Psychiatric Therapy".
E. All procedures listed in the CPT or HCPCS description as "Unlisted" or "Unspecified" which end in "99".
F. Services billed using non-covered CPT or HCPCS codes.

G. Educational supplies, medical testimony, special reports, travel by the physician, no-show or canceled appointments, additional allowances for services provided after office hours or between 10:00 p.m. and 8:00 a.m. or on Sundays or holidays, calls, visits or consultations by telephone and other related services.

H. Routine lab and x-ray services required on hospital admissions.

I. Biofeedback or hypnotherapy.

J. Services provided free of charge to Medicaid members by County Health Divisions or State Laboratories (e.g., metabolic screens for members under one year of age).

K. Investigational items and experimental services, drugs or procedures or those not recognized by the Federal Drug Administration, the United States Department of Health and Human Services, Medicare, and the Division's medical peer review contractor as universally accepted treatment.

L. Services or procedures performed without regard to the policies contained in this Policy Manual.

M. Services normally provided free of charge to indigent patients, e.g., free clinics.

N. Hospital visits to members awaiting placement in a nursing home, unless medically necessary.

O. Hospital visits if the hospital admission or length of stay is disallowed by the Hospital Utilization Review staff or the Division.

P. Radiological procedures performed by a portable x-ray service.

Q. Services provided in a State-owned facility; drugs used in the physician's office or dispensed by the physician except those injectables authorized on the Physicians Injectable Drug List.

R. Tubal reanastomosis.

S. ESRD dialysis Services for Medicare-Only members.

T. Hospital admissions and daily visits for maintenance dialysis.

U. Office visits for maintenance dialysis; insertion or removal of catheters or shunt declotting for dialysis patients enrolled in the Dialysis Services Program.

V. Penile prosthesis.

W. Psychiatric Pharmacologic Management (CPT code 90862).

X. Infertility procedures and related services.

Y. Hermography.

Z. Substance Abuse Clinic Services.

CC. Vaccines for members less than nineteen years of age that are available through the VFC Program.

DD. Sensitivity training, encounter groups, or workshops.

EE. Sexual competency training.

FF. Education testing and diagnosis.

GG. Marriage or guidance counseling.

HH. Psychiatric services rendered through, by or in mobile units or facilities other than the physician's office, nursing facility, or acute care hospital (non-psychiatric). A mobile unit shall not constitute a physician's office for psychiatric services.

II. Interactive psychotherapy.

JJ. Psychiatric services provided to patients in Therapeutic Residential Treatment programs.

KK. Chiropractic Services (not applicable to Chiropractic Services covered by Medicare as a primary carrier).

LL. Provider Preventable Conditions (PPCs), Never Events (NEs), and Hospital Acquired Conditions (HACs). "If any physician is found to be involved in a HAC/Never Event adverse situation affecting an enrolled Medicaid member, all associated and billable charges will be recouped for the days involving the incident". (Refer to Appendix Y for details related to PPCs, NEs, and HACs).

To appeal non-covered medically necessary services, call 1-800-766-4456, or email a request via the Web Portal (www.mmis.georgia.gov), and select "Contact Us".

PART II

CHAPTER 1000

BASIS FOR REIMBURSEMENT

1001 Reimbursement Methodology

The Division will pay the lower of the physician's lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, or the lowest price charged to other third party payers, or the statewide maximum allowable reimbursement amount allowed for the procedure code reflecting the service rendered. Effective with dates of service July 1, 2003, the statewide maximum allowable reimbursement is 84.645% of the 2000 Resource Based Relative Value Scale (RBRVS) as specified by Medicare for Georgia Area 1 (Atlanta). All procedure codes recognized and adopted after the 2000 RBRVS are subject to the same level of reimbursement.

Services provided by a physician's assistant are limited to no more than 90% of the maximum allowable amount paid to a physician.

The Division's Schedule of Maximum Allowable Payments (by procedure code) is available at www.mmis.georgia.gov

This is not a fee schedule As required in section 601.4 physicians must bill the lowest price regularly and routinely offered to any segment of the general public for the same service or item on the same date of service, or the lowest price charged to other third party payers for the procedure code most closely reflecting the service rendered.

Medicare Crossover Claims

Policies and Procedures for Medicaid PeachCare for Kids Part 1 Manual Division state that payments for Medicare coinsurance and deductible obligations are limited to the Medicaid maximum allowable payment. The Division will modify its claim payment system to apply this policy effective with payments made on and after October 1, 2000 as follows:

Physician Services

1. The Medicaid maximum allowable payment is the amount from the Division's Schedule of Maximum Allowable Payments for each applicable procedure code.

2. The Medicare coinsurance and deductible amounts for a claim are compared to the sum of the Medicaid maximum allowable amounts for each procedure code minus the Medicare payment.

3. The actual Medicaid payment will be the lower of the amounts in item 2, less applicable third party liabilities and patient co-payments.

These changes would apply to services provided to all patients dually eligible for the Medicaid and Medicare programs, including Qualified Medicare Beneficiaries

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Contact Information

DXC Technology

Member and Provider Correspondence
DXC Technology
P.O. Box 105200
Tucker, GA. 30085-5200
Fax: (866) 483-1045

Provider Enrollment
Access on-line at www.MMIS.Georgia.gov

Electronic Data Interchange (EDI)
1-800-987-6715

- Asynchron
- Web Portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/
- Internet Protocol (TCP/IP

Provider Inquiry Number:
1-800-766-4456

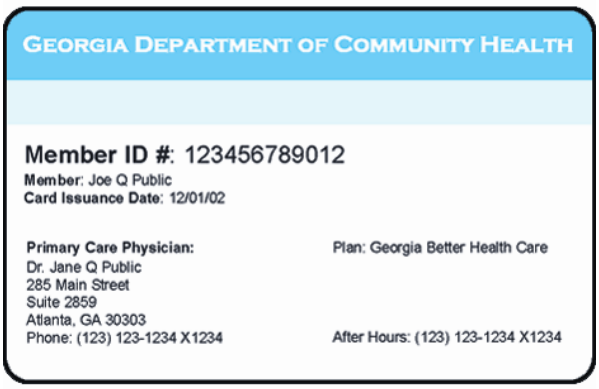
The web contact address is:
http://www.mmis.georgia.gov

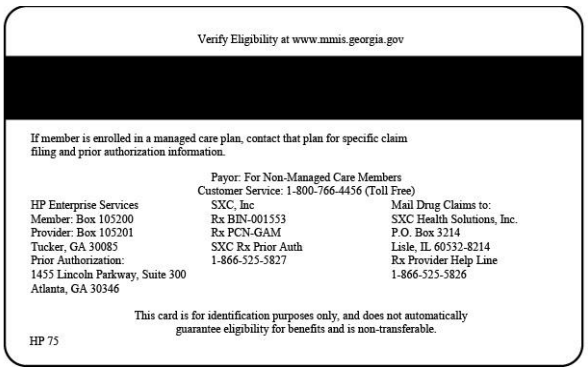
APPENDIX A

MEDICAL ASSISTANCE ELIGIBILITY CERTIFICATION

Medicaid & PeachCare for Kids Member Identification Card Sample

This card replaces former member ID cards for both FFS Medicaid and PeachCare for Kids Plans.





Note: Providers are required to verify member eligibility prior to rendering service before each visit.

Emergency Medical Assistance (EMA) Eligibility

Currently, immigrants, including undocumented immigrants, who would be eligible for Medicaid except for their immigrant status, are potentially eligible for Emergency Medical Assistance. This includes persons who are aged, blind, disabled, pregnant women, children, or parents of dependent children who meet eligibility criteria. Services rendered to Emergency Medical Assistance (EMA) recipients are limited to emergency care only. As described in the Federal Regulations 1903 (v) of the Social Security Act and the Code of Federal Regulation 42 CFR 440.255 emergency services are those that are:

1. Medically necessary:
2. Result from the sudden onset of a health condition with acute symptoms, and:
3. In the absence of immediate medical attention, are reasonably likely to result in at least one of the following:
    - Placing the individuals health in serious jeopardy:
    - Serious impairment to bodily functions:
    - Serious dysfunction of any bodily organ or part:

A physician must verify that the service has been rendered. The physician verifies emergency medical services by completing DMA Form 526, “Physician’s Statement for Emergency Medical Assistance”. The form must be submitted to the County Department of Family and Children Services or out stationed Medicaid Worker as part of the Medicaid eligibility determination.

Except for emergency labor and delivery services only (prenatal and postpartum care is not covered) all claims for services provided to members eligible under the Emergency Medical Assistance program will be reviewed by the Alliant Health Solutions on a case-by-case basis. Provider claims must be submitted with documentation that supports the emergent nature of the services provided.

APPENDIX B

VACCINES FOR CHILDREN PROGRAM

Immunization - Vaccines for Children (VFC) General

The new federal vaccine program will provide you with free vaccines to be used for all children under nineteen years old except those who have insurance, which covers immunizations. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) created the funding for this program called Vaccines for Children (VFC).

The Georgia VFC program will supply vaccines for the following:

1. Children enrolled in Medicaid or qualified through a Medicaid waiver
2. Children who do not have health insurance
3. Children who are American Indian or Alaskan Native
4. Children who have health insurance but vaccines are not a covered benefit; and
5. Children enrolled in PeachCare for kids

The State Department of Public Health will be responsible for enrolling physicians, physician's assistants, nurse practitioners and nurse midwives into the program and processing the vaccine orders.

All physicians, physician's assistants, nurse midwives and nurse practitioners who provide immunization services must enroll in the Vaccines for Children program and provide immunizations to Medicaid eligible children whose ages are birth through eighteen (18) years of age.

Enrollment

Providers who give immunizations to Medicaid children must be enrolled in the VFC program.

Providers who wish to enroll must complete the Provider Enrollment Form, the Provider Profile and the Vaccine Order Form and return to:

Georgia Immunization Program
P. O. Box 949
Atlanta, Georgia 30301-0949
Number: (404) 657-5013 or toll free 1-800-848-3868

Providers in Group Practices need only complete one Enrollment Form. However, a copy of the license of each provider must be attached to the Enrollment Form. A Provider Profile must be completed for each location (separate office, clinic, etc.) where immunizations are given.

Each individual provider must attach a copy of their license to the enrollment form. Questions regarding enrollment, vaccine orders and record keeping should be directed to the Georgia Immunization Program.

For a complete list of procedure codes to bill for Immunizations (ages birth up to 19 years), Tuberculin Skin Tests and Blood Lead Tests, please refer to the Health Check Services program manual. Bill only Health Check Program procedure codes on the same claim form. Bill other Medicaid program (i.e., Physician Services Program, etc.) procedure codes on a separate CMS 1500 Claim Form.

APPENDIX B1

VACCINES COVERED IN THE PHYSICIAN AND ADVANCED NURSE PRACTITIONER SERVICE PROGRAMS

CPT Code	Vaccines	Age Restriction	Diagnosis Restriction
90378	Palivizumab (Synagis) 50mg vial *Effective 10/2006, PA required prior to administering.*	Limited to newborns to age 3 years	Usage is limited to perinatal chronic respiratory disease and low birth weight
90585	Bacillus Calmette-Guerin (BCG) For tuberculosis, live, for percutaneous use	None	None
90586	Bacillus Calmette-Guerin (BCG) For bladder cancer, live, for intravesical use	None	None
90632	Hepatitis A Vaccine, adult dosage, for intramuscular use	Limited to age 21 and older	None
90633	Hepatitis A Vaccine, pediatric/adolescent dosage - 2 dose schedule, for intramuscular use	Limited to age 19 to 21 years	None
90634	Hepatitis A Vaccine, Pediatric/adolescent dosage- 3 dose schedule, for intramuscular use	Limited to age 19 to 21 years	None
90636	Hepatitis A and Hepatitis B Vaccine (HepA-HepB), adult dosage, for intramuscular use	Limited to age 21 and older	None
90649	Human Papilloma Virus (HPV) Vaccine, Types 6, 11, 16, 18 (Quadrivalent), 3 dose schedule, for IM use [Gardasil]	Limited to female 9-21 years	None
90650	Human Papilloma Virus (HPV) Vaccine, Types 16, 18 Bivalent, 3 doses schedule, for intramuscular use [Cervarix]	Limited to females 21-26 years	None

CPT Code	Vaccines	Age Restriction	Diagnosis Restriction
90651	Human Papillomavirus Vaccine Types 6, 11, 16, 18, 31, 33, 45, 52, 58, Nonavalent (HPV), 3 dose schedule, for intramuscular use [Gardasil]	Limited to females 21-26 years	None
90656	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intra muscular use	Limited to age 3 years and older	None
90675	Rabies vaccine, for intramuscular use	None	None
90707	Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous or jet injection use	Limited to age 19 to 21 years	None
90713	Poliovirus vaccine, inactivated, (IPV), for subcutaneous use	Limited to age 19 to 21 years	None
90714	TETANUS AND DIPHTHERIA TOXOIDS (TD) ADSORBED, PRESERVATIVE FREE, WHEN ADMINISTERED TO INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	Limited to age 19 and older	None
90715	TETANUS, DIPHTHERIA TOXOIDS AND ACELLULAR PERTUSSIS VACCINE (TDAP), WHEN ADMINISTERED TO INDIVIDUALS 7 YEARS OR OLDER, FOR INTRAMUSCULAR USE	Limited to 19 and older	None
90716	Varicella virus (Chicken Pox) vaccine, live, for subcutaneous use	None	None
90732	Pneumococcal polysaccharide vaccine, 23-valent, adult or immunosuppressed patient dosage, for subcutaneous or intramuscular use	Limited to age 50 to 99 years	None
90733	Meningococcal polysaccharide vaccine (any group(s)), for subcutaneous or jet injection use	Limited to age 1 and older	None
90736	ZOSTER (SHINGLES) Vaccine, live, for SQ injection (Zostvac)	Over age 60	None
90746	Hepatitis B vaccine, adult dosage, for intramuscular use	Limited to age 21 to 999 years	None

CPT Code	Vaccines	Age Restriction	Diagnosis Restriction
90747	Hepatitis B vaccine, dialysis or immunosuppressed patient dosage (4 dose schedule), for intramuscular use	None	Usage is limited to renal failure and AIDS diagnoses
90748	Hepatitis B & Hemophilus influenza b vaccine (HepB-Hib), for intramuscular use	Limited to age 19 to 21 years	None

APPENDIX BB

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(Refer to the Part 1 Medicaid and Peachcare for Kids Manual, Appendix J, ICD-10 Overview policy)

Appendix C

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APPENDIX D

HEALTH CHECK AND ADULT PREVENTIVE VISIT

The mission of the Department of Community Health (Department) goal is to improve the health outcomes of our enrolled Medicaid members by allowing them to establish a medical home and receive preventive health services.

Health Check

The Health Check program is Georgia Medicaid's well-child or preventive health care program for children birth to twenty-one (21) years of age. It is the early and periodic screening, (EPS) component of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. EPSDT is the result of a 1967 Amendment of Title XIX of the Social Security Act, which directed attention to the importance of preventive health services for children. The Medicaid manual for the Health Check program covers the screening (EPS) policies and procedures for well-child check-ups. The screening consists of a comprehensive unclothed physical examination, a comprehensive health and developmental history, developmental assessment, anticipatory guidance, measurements, age appropriate vision and hearing tests, certain laboratory procedures and lead risk assessment.

NOTE: Please refer to the Health Check Manual for children birth to twenty-one (21) years of age for specific details.

Adult Preventive Visit

Effective January 1, 2016, the Department of Community Health will implement one adult preventive visit for members 21 years of age and older. The members will have access to one preventive health visit each calendar year (CY) and 10 office visits (Evaluation and Management codes 99201 - 99215) each CY. Additional office visits (above the 10 visits) will still be available based upon documentation and supporting medical necessity that must be sent to Alliant Health Solutions for review. Providers may bill ONE (1) preventive health visit (993XX) for a member annually (between January and December of the CY). Providers must use one of the following ICD-10 diagnosis codes when billing the preventive health visit code: Z00.00 or Z00.01 (Encounter for adult examination). Each member is allowed 10 office visits (992XX) per CY without prior authorization.

The following preventive procedure codes and services are available for reimbursement for adult preventive annual visit:

Adult preventive services provides reimbursement for following preventive health services:

- 99385 or 99395 - (Adults 21 through 39 years of age).
- 99386 or 99396 - (Adults 40 through 64 years of age)
- 99387 or 99397 - (Adults 65 years and older)

Adult preventive services benefits include, but not limited to the following:

Immunization:

- Influenza vaccination *
- Pneumococcal vaccination*
- Tetanus Diphtheria (Td) *
- Zoster vaccination
- Hepatitis A & B
- Measles, mumps, rubella (MMR) *
- Meningococcal
- Varicella *
- Human papillomavirus (HPV) for Women and Men *

Screening

- Breast cancer screening *
- Testicular and Prostate screening *
- Cervical cancer screening *
- Colorectal cancer screening *
- Cholesterol screening *
- Body Mass Index (BMI) *
- Diabetes
- Hearing Assessment
- Vision (Glaucoma)
- Lipid Disorders
- Osteoporosis
- Smoking Cessation

* Adult Preventive HEDIS measures, as defined by National Committee for Quality Assurance (NCQA).

APPENDIX E

PRIOR APPROVAL AND/OR PREPAYMENT REVIEW

Procedures and services listed in APPENDIX E require a PA regardless to age or place of service. Certain services may also be subject to pre-payment review.

Prior approval (PA) for certain procedures, may be completed telephonically; while others are limited to written or web submission only. For further information, contact the DXC Technology at (800) 766-4456 (Toll free).

The following list of procedure codes is not intended by exhaustive-due to the CPT code revisions occurring throughout the year. All procedures that fall into the general categories or family of code-listed in Section 801 must be prior approved.

A. Procedures Which Require Prior Approval

Rev. 07/08

Integumentary System

Skin, Subcutaneous, and Accessory Structures

Excision-Benign Lesions

Rev 12/09	11440	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5cm or less
	11441	excised diameter 0.6 to 1.0 cm
	11442	excised diameter 1.1 to 2.0 cm
	11443	excised diameter 2.1 to 3.0 cm
	11444	excised diameter 3.1 to 4.0 cm
	11446	excised diameter over 4.0 cm
	11920	Tattooing, intradermal introduction of insoluble opaque pigments to correct color defects of skin, including micropigmentation; 6.0 sq cm or less
	11921	6.1 to 20 sq cm
	11922	each additional 20.0 sq. cm or part thereof (List separately in addition to code for primary procedure)
	11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion

	11970	Replacement of tissue expander with permanent prosthesis

Repair (Closure)

Other Procedures

Rev.12/09	15780	Dermabrasion; total face (eg, for acne scarring, fine wrinkling, rhytids, general keratosis)
	15781	Less than face (cheeks, chin, perioral area, forehead, or nose)
	15782	Regional, other than face
	15820	Blepharoplasty, lower eyelid;
	15821	With extensive herniated fat pad
	15822	Blepharoplasty, upper eyelids
	15823	With excessive skin weighting down lid
Rev.12/09	15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
	15832	Thigh
	15833	Leg
	15834	Hip
	15835	Buttock
	15836	Arm
	15837	Forearm and hand
	15838	Submental fat pad
	15839	Other area
	15876	Suction assisted lipectomy; head and neck
	15877	Trunk
	15878	Upper extremity
	15879	Lower extremity

Destruction, Benign or Prealignant Lesions

17106 Destruction of cutaneous vascular proliferative lesions; less than 10 sq cm

17107 10.0 to 50.0 sq cm

17108 Over 50.0 sq cm

Breast

Rev.12/09

Mastectomy Procedures

19300 Mastectomy of gynecomastia

Repair and/or Reconstruction

Rev.12/09

19316 Mastopexy

19318 Reduction mammaplasty

19324 Mammaplasty, augmentation; without prosthetic implant

19325 With prosthetic implant

When requesting prior approval on the above specific procedures, photos must be forwarded with your request for prior approval.

19340 Immediate insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19342 Delayed insertion of breast prosthesis following mastopexy, mastectomy or in reconstruction

19350 Nipple/areola reconstruction

19357 Breast reconstruction, immediate or delayed, with tissue expander including subsequent expansion

19361 Breast reconstruction with latissimus dorsi flap, without prosthetic implant

19364 Breast reconstruction with free flap

19366 Breast reconstruction with other technique

19367 Breast reconstruction with traverse rectus abdominis myocutaneous flap (TRAM), single pedicle, including closure of donor site;

19368 With microvascular anastomosis (supercharging)

19369 Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM), double pedicle, including closure of donor site

19380 Revision of reconstructed breast

Musculoskeletal System

Head

Excision

21011 Excision, tumor, soft tissue of face or scalp, subcutaneous; less than 2 cm

21012 2 cm or greater

21013 Excision, tumor, soft tissue of face and scalp, subfacial (eg, subgaleal, intramuscular); less than 2 cm

21014 2 cm or greater

21015 Radical resection of tumor (eg, malignant neoplasm), soft tissue of face or scalp; less than 2 cm

21016 2 cm or greater

Repair Revision, and/or Reconstruction

Rev.12/09

21150 Reconstruction midface, LeFortII; anterior intrusion

21151 Any direction, requiring bone grafts

21154 Reconstruction midface, LeFort III, any type, requiring bone grafts without LeFort I

21155 With LeFort I

21159 Reconstruction midface, LeFort III with forehead advancement, requiring bone grafts; without LeFort I

21160 With LeFort I

21172 Reconstruction superior-lateral orbital rims and lower forehead, advancement or alteration, with or without grafts

21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration with or without grafts

21179 Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts

21180 With autograft

21181 Reconstruction by contouring of benign tumor of cranial bones, extra cranial

21182 Reconstruction of orbital walls, rims, forehead, nasoethmoid complex following intra- and extracranial excision of benign tumor of cranial bone, with multiple autografts; total area of bone grafting less than 40 sq cm

21183 total area of bone grafting greater than 40 sq cm but less than 80 sq cm

21184 Total area of bone grafting greater than 80 sq cm

21188 Reconstruction midface, osteotomies and bone grafts

21193 Reconstruction of mandibular rami, horizontal, vertical, C, or L osteotomy; without bone graft

21194 With bone graft (includes obtaining graft)

21195 Reconstruction of mandibular rami and/or body, sagittal split; without internal rigid fixation

21196 With internal rigid fixation

21198 Osteotomy, mandible, segmental;

21199 With genioglossus advancement

Neck (Soft Tissues) and Thorax

Rev.07/09

Repair, Revision, and/or Reconstruction

21740 Reconstructive repair of pectus excavatum or carinatum; open

21742 Minimally invasive approach (Nuss procedure), without thoracoscopy

21743 Minimally invasive approach (Nuss procedure), with thoracoscopy

Forearm and Wrist

Rev.12/09

Vertebroplasty and Vertebral Augmentation

22510 Injection of bone cement, middle spine

22511 Injection of bone cement, lumbosacral

22512 Injection of bone cement, middle or lower spine

22513 Injection of bone cement, middle spine

22514 Injection of bone cement, lumbar

22515 Injection of bone cement, thoracic or lumbar

Arthrodesis

25830 Arthrodesis, distal radioulnar joint with segmental resection of ulna, with or without bone graft (e.g., Sauve-Kapandji procedure)

Leg (Tibia and Fibula) and Ankle Joint

Arthrodesis See Appendix O for 27685-27745

22867 Insertion of inter laminar stabilization device into lower spine with open decompression

22869 Insertion of inter laminar stabilization device into lower spine at single level

27870 Arthrodesis, ankle, open

27871 Arthrodesis, tibiofibular joint, proximal or distal

28035 Decompression of Tibia Nerve

Foot and Toes

Excision

28130 Talectomy (astragalectomy)

28140 Metatarsectomy

28150 Phalangectomy, toe, each toe

28153 Resection, condyle(s), distal end of phalanx, each toe

28160 Hemiphalangectomy or interphalangeal joint excision, toe, proximal end of phalanx, each

Repair, Revision, and/or Reconstruction

28234 Tenotomy, open, extensor, foot or toe, each tendon

28238 Reconstruction (advancement) posterior tibial tendon with excision of accessory tarsal navicular bone (eg, Kidner type procedure)

28250 Division of plantar fascia and muscle (eg, Steindler stripping) (separate procedure)

28260 Capsulotomy, midfoot; medial release only (separate procedure)

28261 With tendon lengthening

28262 Extensive, including posterior talotibial capsulotomy and tendon(s) lengthening (eg, resistant clubfoot deformity)

28264 Capsulotomy, midtarsal (Heyman type procedure)

28270 Capsulotomy; metatarsophalangeal joint, with or without tenorrhaphy, single, each joint (separate procedure)

28272 Interphalangeal joint, each joint (separate procedure)

28280 Syndactylization, toes (eg, webbing or Kelikian type procedure)

28285 Correction, (eg, interphalangeal fusion, partial or total phalangectomy)

28286 Correction, cock-up fifth toe, with plastic skin closure (eg, Ruiz-Mora type procedure)

28290 Correction, hallux valgus (bunion), with or without sesamoidectomy; simple exostectomy (eg Silver type procedure)

28291 Correction of ridged deformity of first joint or big toe using implant

28292	Keller, McBride or Mayo type procedure
28293	Resection of joint with implant
28294	With tendon transplants (eg, Joplin type procedure)
28295	Correction of bunion
28296	with metatarsal osteotomy (eg, Mitchell, Chevron, or concentric type procedures)
28297	Lapidus-type procedure
28298	By phalanx osteotomy
28299	By double osteotomy
28300	Osteotomy, calcaneus (eg, Dwyer or Chamber type procedure), with or without internal fixation
28302	Osteotomy; talus
28304	Osteotomy, tarsal bones, other than calcaneus or talus;
28305	With autograft (includes obtaining graft) (eg, Fowler type)
28306	Osteotomy, with or without lengtheningmetatarsal, shortening or angular correction; metatarsal; first metatarsal
28307	First metatarsal with autograft (other than first toe)
28308	Other than first metatarsal
28309	Multiple, (eg, Swanson type cavus foot procedure)
28310	Osteotomy for shortening, angular or rotational correction; proximal phalanx, first toe (separate procedure)
28312	Other phalanges, any toe
28313	Reconstruction, angular deformity of toe, soft tissue procedures only (eg, overlapping second toe, fifth toe, curly toes)
28315	Sesamoidectomy, first toe (separate procedure)
28320	Repair of nonunion or malunion; tarsal bones
28322	Metatarsal, with or without bone graft (includes obtaining graft)
28345	Syndactyly, with or without skin graft(s), each web

Arthrodesis

Rev/12/09

28705 Arthrodesis; pantalar

28715 Triple

28725 Subtalar

28730 Arthrodesis, midtarsal or tarsometatarsal multiple or transverse

28735 With osteotomy (eg, flatfoot correction)

28737 Arthrodesis, with tendon lengthening and advancement, midtarsal navicular-cuneiform (eg, Miller type procedure)

28740 Arthrodesis, midtarsal or tarsometatarsal, single joint

28750 Arthrodesis, great toe; metatarsophalangeal joint

28755 interphalangeal joint

28760 Arthrodesis, with extensor hallucis longus transfer to first metatarsal neck, great toe, interphalangeal joint (eg, Jones type procedure) (For hammertoe operation or interphalangeal fusion, see 28285)

Respiratory System

Rev/12/09

Nose

Excision

30130 Excision inferior turbinate, partial or complete, any method

30140 Submucous resection inferior turbinate, partial or complete, any method

Repair

Rev.12/09

30400 Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip

30410 Complete, external parts including bony pyramid, lateral and alar cartilages and/or elevation of nasal tip

30420	Including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount nasal tip work)
30435	Intermediate revision (bony work with osteotomies)
30450	Major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft

Destruction

30801	Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method, (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial
30802	Intramural (i.e., submucosal)
31295	Nasal/Sinus Endoscopy, Surgical; with dilation of maxillary sinus ostium (eg, balloon dilation), transnasal or via canine fossa
	Rev.04/11
	Rev.04/13
31296	Nasal /sinus Endoscopy, Surgical; with dilation of frontal sinus ostium (eg, balloon dilation)
31297	Nasal/sinus Endoscopy, Surgical; with dilation of sphenoid sinus ostium (eg, balloon dilation)
31551	Repair or narrowed voice box with graft, younger than 12 years of age
31552	Repair of narrowed voice box with graft, patient age 12 years or older
31553	Repair of narrowed voice box with graft and placement of stent, younger than 12 years of age

31554	Repair of narrow voice box with graft and placement of stent, patient age 12 years of age
31572	Destruction of abnormality of one side of voice box using a flex endoscope
31573	Injection of drug into one side of voice box using a flexible endoscope
31574	Injection of substance to augment voice box using a flexible endoscope
31967	Nasal /sinus Endoscopy, Surgical; with dilation of sinus ostium (eg, balloon dilation)
32701	Sterotatic Radiation- Thoracic target delineation for SRS/SRBT

Cardiovascular System

Heart and Pericardium

Transmyocardial Revascularization

33140	Transmyocardial laser revascularization, by thoracotomy; (separate procedure)
37248	Ballon dilation of first vein, through the skin or open procedure
33270	Insertion or replacement of defibrillator with electrode
33340	Repair of left upper heart
33390	Simple repair of aortic value by open procedure on heart lung machine
33391	Complex repair of aortic value by open procedure on heart lung machine

Arteries and Veins

36473	Mechanicochemical destruction of insufficient vein of arm or leg

Ligation

37700	Ligation and division of long saphenous vein at saphemofemoral junction, or distal interruptions
37718	Ligation, division, and stripping, short saphenous vein

37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia
37246	Ballon dilation of artery, accessed through the skin, with imaging
37760	Ligation of perforator veins, subfascial, radical (Linton type), including, when performed, open, 1 leg
37761	Ligation of perforator vein(s), subfacial, open, including ultrasound guidance, when performed, 1 leg
37765	Stab phlebectomy of varicose veins, 1 extremity, 10-20 stab incisions
37766	More than 20 incisions

Hemic and Lymphatic Systems

General

Bone Marrow or Stem Cell Services/Procedures

38240	Bone marrow or blood-derived peripheral stem cell transplantation; allogenic
38241	Autologous
38243	Transplant or post transplantation Cellular Infusion HPC boost

Insertion of Central Venous Access Device

36555	Insertion of non-tunneled centrally inserted central venous catheter, younger than 5 years of age
36556	Insertion of non-tunneled centrally inserted central venous catheter, age 5 years or older

Digestive System

Stomach

Laparoscopy

43284	Placement of augmentation device in sphincter of esophagus
43285	Removal of augmentation device from sphincter of esophagus

43651 Laparoscopy, surgical; transection of vagus nerves, truncal

43652 Transection of vagus nerves, selective or highly selective

Bariatric Surgery

43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device (eg, gastric band and subcutaneous port components

43771 Revision of adjustable gastric restrictive device component only

43772 Removal of adjustable gastric restrictive device component only

43773 Removal and replacement of adjustable gastric restrictive device component only

43774 Removal of adjustable gastric restrictive device and subcutaneous port components

Other Procedures

43842 Gastoplasty, vertical-banded

43843 Gastoplasty, other than vertical-banded

43845 Partial gastrectomy, duodenoileostomy and ileoileostomy

43846 Gastric bypass with Roux-en-Y gastro enterostomy

43847 Gastric by-pass, short limb Roux-en-Y with small bowel reconstruction

43848 Revision of gastric restrictive procedure for morbid obesity

43886 Revise gastric port, open

43887 Remove gastric post, open

43888 Change gastric port, open

46601 Diagnostic examination of anus

46607 Biopsies of anus

Liver Transplantation

47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age

47140 Donor hepatectomy (including cold preservation), from living donor; left lateral segment only (segments II and III)

47141 total left lobectomy (segments II, III, and IV)

47142 total right lobectomy (segments V, VI, VII and VIII)

Laparoscopy

49321 Laparoscopy, surgical; with biopsy (single or multiple)

49322 With aspiration of cavity or cyst (eg, ovarian cyst) (single or multiple)

49323 With drainage of lymphocele to peritoneal cavity

49324 Laparoscopy, surgical; with biopsy (single or multiple) with drainage of lymphocele to peritoneal cavity

49325 With revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed

Note: Liver transplants are covered for eligible children under age 18 with extrahepatic biliary atresia and other forms of end-stage liver disease. Liver transplants also are covered for members over age 18 that have one of the following diagnoses.

- **End stage cirrhosis with liver failure due to:**
    a. Primary biliary cirrhosis
    b. Chronic active hepatitis (except as below)
    c. Secondary biliary cirrhosis
    d. Other disorders not likely to recur in the graft and which are not associated with serious coexisting system disease
    e. Cause unknown
- **Metabolic diagnoses involving the liver, including:**
    a. Alpha 1-antitrypsin deficiency
    b. Protoporphyrin
    c. Crigler-Najjar syndrome type I

d. Other metabolic disorders involving the liver for which no effective therapy exists and which are not associated with serious extrahepatic diseases.

- **Miscellaneous diagnoses including:**

  a. Hepatic vein thrombosis

  b. Sclerosing cholangitis

  c. Other disorders not listed above which are not associated with serious and irreversible extrahepatic disease, which produce life-threatening illness, for which no other effective therapy exists, and for which transplantation would be beneficial.

Note: Each case will be reviewed by a physician specialty panel from the DXC Technology for a decision determination.

Male Genital System

54483 Replantation, penis, complete amputation including urethral repair

Prostate

Other Procedures

55875 Transperineal placement of needles or catheters into prostate for interstitial radioelement application, with or without cystoscopy

55876 Placement of interstitial device(s) for radiation therapy guidance (eg, fiducial markers, dosimeter), prostate (via needle, any approach), single or multiple.

Female Genital System

Vagina

Repair

57291 Construction of artificial vagina; without graft

57292 with graft

Corpus Uteri

Excision

58150 Total abdominal hysterectomy (corpus and cervix) with or without removal of tube(s), with or without removal of ovary(s)

58152 With colpo-urethrocystopexy (Marshall-Marchetti-Krantz, Burch type)

58180 Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)

58200 Total abdominal hysterectomy, including partial vaginectomy, with para-aortic pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)

58210 Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)

58240 Pelvic exenteration for gynecologic malignancy, with total abdominal hysterectomy or cervicectomy with or without removal of tube(s), with or without removal of ovary(s), with removal of bladder and urethral transplantations, and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof (For pelvic exenteration for lower urinary tract or male genital malignancy, use 51597)

58260 Vaginal hysterectomy for uterus 250g or less;

58262 With removal of tube(s), and/or ovary(s)

58263 With removal of tube(s), and/or ovary(s), with repair of enterocele

58270 With repair of enterocele

58275 Vaginal hysterectomy, with total or partial vaginectomy

58280 with repair of enterocele

58285 Vaginal hysterectomy, radical (Schauta type operation)

Laparoscopy/Hysteroscopy

58550 Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 g or less

58552 With removal of tube(s) and/or ovary(s)

58553 Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 g

58554 With removal of tube (s) and/or ovary (s)

58570 Laparoscopy,surgical, with total hysterectomy, for uterus 250 g or less

58571 Laparoscopy, surgical, with total hysterectomy, for uterus 250 G or less; with removal of tube (s) and/or ovary (s)

58572 Laparoscopy, surgical , with total hysterectomy, for uterus greater than 250 g

58573 With removal of tube (s) and/or ovary(s)

58674 Destruction of fibroid tumor of uterus using a laparoscope

Maternity Care and Delivery

Antepartum and Fetal Invasive Services

59072 Fetal umbilical cord occlusion, including ultrasound guidance

59076 Fetal shunt placement, including ultrasound guidance

Cesarean Delivery

59525 Subtotal or total hysterectomy after cesarean delivery (this is an add-on code and is subject to add-on stipulations)

Nervous System

Skull, Meninges, and Brain

Endovascular Therapy

65 Transcatheter placement of intravascular stent(s), intracranial (eg, atherosclerotic stenosis), including balloon angioplasty, if performed

Neurostimulators (Intracranial)

61885 Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to a single electrode array

61886 With connection to 2 or more electrode arrays

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System

Neurostimulators (Peripheral Nerve)

62320	Injection of substance into spinal canal of upper /middle back
62321	Injection of substance into spinal canal of upper/middle back w/imaging
62322	Injection of substance into spinal canal of lower back w/imaging
62323	Injection of substance into spinal canal of lower back w/ imaging
62324	Injection of indwelling catheter and administration of substance into spinal canal of upper or middle back
62325	Insertion of indwelling catheter and administration of substance into spinal canal of upper middle back
62326	Insertion of indwelling catheter and administration of substance into spinal canal of lower back w/imaging
62327	Insertion of indwelling catheter and administration of substance into spinal canal of lower back w/imaging
62380	Decompression of spinal cord/nerve root in lower back using endoscope
64405	N Block Inj Occipital
64445	Sciatic nerve, single
64446	Sciatic nerve, continuous infusion by catheter
64449	Lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
64461	Paravertebral block, thoracic; single injection site
64462	Second and any additional injection site
64463	Continuous infusion by catheter
64479	Injection (s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT) cervical or thoracic, single level
64480	Cervical or thoracic, each additional level (List separately in addition to code for primary procedure)
	Implantation of intrastromal corneal ring segments

64490	Injection (s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Second level (List separately in addition to code for primary procedure)
64492	Third and any additional level(s) (List separately in addition to code for primary procedure)
64493	Injection (s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Second level (List separately in addition to code for primary procedure
64495	Third and any additional level(s) (List separately in addition to code for primary procedure
64530	Celiac plexus,with or without radiologic monitoring
64561	Sacral nerve (transforaminal placement) including image guidance, if performed
64581	Sacral nerve (transforaminal placement)
64611	Chemodenervation of parotid and submandibular salivary gland, bilateral
64612	Chemodenervation of muscles(s); muscle(s) innervated by facial nerve, unilateral
64615	Muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
64616	Neck muscle(s), excluding muscles of the larynx, unilateral
64617	Injection of chemical for destruction of nerve muscles on one side of voice box accessed through the skin
64642	Injection of chemical for destruction of nerve muscles on arm or leg, 1-4 muscles
64643	Each additional extremity, 1-4 muscle(s)
64644	Injection of chemical for destruction of nerve muscles on arm or leg,5 or more muscles
64645	Each additional extremity, 5 or more muscle(s)

64646 Injection of chemical for destruction of nerve muscles on trunk, 5 or more muscles

64647 Injection of chemical for destruction of nerve muscles on trunk, 6 or more muscles

Eye and Ocular Adnexa

Anterior Segment

Cornea

65710 Keratoplasty (corneal transplant); anterior lamellar

65730 Penetrating (except in aphakia or pseudophakia)

65750 Penetrating (in aphakia)

65755 Penetrating (in pseudophakia)

65756 Endothelial

65780 Ocular surface reconstruction; amniotic membrane transplantation

65781 Limbal stem cell allograft (eg, cadaveric or living donor)

65782 Limbal conjunctival autograft,(includes obtaining graft)

Ocular Adnexa

Eyelids

67900 Repair of brow ptosis

67903 (tarso) levator resectionor advancement, internal approach

67904 (tarso) levator resectionor advancement, internal

67906 Superior rectus technique with fascial sling (includes obtaining fasica)

67908 Conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type

67909 Reduction of overcorrection of ptosis

Auditory System

External Ear

Repair

69300 Othoplasty, protruding ear, with or without size reduction

Middle ear

Other procedures

69714 Implantation, osseointegrated implant, temporal bone, with percutaneous attachment to external speech processor/cochlear stimulator; without mastoidectomy

69715 With mastoidectomy

Inner Ear

Introduction

69930 Cochlear device implantation, with or without mastoidectomy

Radiology

Diagnostic Radiology (Diagnostic Imaging)

Head and Neck

Spine and Pelvis

Abdomen

77371 Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based

77372 Linear accelerator based

77373 Stereotactic body radiation therapy, treatment delivery, per fraction to 1 or more lesions, including image guidance, entire course not to exceed 5 fractions

Medicine

Gastroenterology

91110 Gastrointestinal tract imaging, intraluminal (eg, capsule endoscopy) esophagus with physician interpretation and report

91112 Capsule endoscopy with gastrointestinal track transit times or pressure.

Special ophthalmological services See Appendix O

Cardiovascular

Echocardiography

93303 Transthoracic echocardiography for congenital cardiac anomalies; complete

On-line Medical Evaluation

Other Services and Procedures

99183 Physician attendance and supervision of hyperbaric oxygen therapy, per session

Photodynamic Therapy See Appendix O

B. Procedures Subjected to Pre-Payment Review:

The following procedure codes describe procedures which could be cosmetic in nature and, therefore, are non-covered by the Georgia Division Of Medicaid. However, if the procedure is performed due to medical necessity rather than for cosmetic reasons, the physician may submit the claim for processing. The claim must have an explanation of the procedure performed (e.g., removal of cyst, mass, etc.) and the medical reason the procedure was required. These explanatory remarks should be made on the face of the claim form in the space under each line entitled "Procedure Description/Remarks".

The claim should be submitted to the normal post office box used for submission and resubmission of the claim.

1. Excision, other benign lesion, face, ears, eyelids, nose, lips, mucous membrane; lesion diameter [Note that approval for the following procedures can only be requested in writing or via web portal.]

   11441 0.6 to 1.0 cm

   11442 1.1to 2.0 cm

   11443 2.1 to 3.0 cm

APPENDIX E

ATTACHMENT "1" TO APPENDIX E

PROTOCOL FOR FACILITY SELECTION - LIVER TRANSPLANT CENTER

1. The staff must have experience in organ transplant program and include a transplant surgeon who has trained at an institution with an established liver transplant program.

2. The staff must include experts in hepatology, gastroenterology, immunology, infectious diseases, nephrology, pulmonary medicine, pediatrics, pathology, pharmacology, anesthesiology, psychiatry, and psychosocial support.

3. The center must give assurance that satisfactory arrangements are in place for donor procurement services.

4. The facility must have an active renal dialysis program and blood bank services which are capable of supplying large quantities of blood on short notice.

5. The hospital should have experience and expertise in the treatment of all types of hepatic diseases.

6. The transplant center administration must have made a commitment to this program and there should be broad-based community support and hospital staff support of this commitment.

7. The center must have a consistent, equitable, and practical protocol for selection of patients.

8. The center should have the capacity and the commitment to conduct systematic evaluations of cost and clinical outcomes of cases.

APPENDIX F

STERILIZATIONS

The Division will make reimbursement only for those sterilization procedures which meet the criteria established in Section 904.1 (a) of this Manual. A copy of the "Informed Consent for Voluntary Sterilization" (Form DMA-69) is attached as Pages F-3 and F-4 of this Appendix. This form must be properly completed on both sides by the member and the attending physician.

Some important points in obtaining and submitting a properly executed Form DMA-69 are listed below.

A. Under the physician's statement

1. The applicable paragraph(1) or (2) must be designated:

   (1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

   (2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on the consent form because of the following circumstances.

   If (2) is designated, the applicable box must be checked and the information requested must be filled in.

   If the box indicating "Premature delivery" is checked, the individual's date of expected delivery must be given on the line provided.

   If the box indicating "Emergency abdominal surgery" is checked, the circumstances of the emergency surgery must be described on the line provided.

2. The physician must sign and date the consent form after the surgery is performed.

3. The physician must sign the consent form. Signature stamps are not acceptable.

B. All lines on the consent form must be completed, with the exception of the interpreter's statement. The interpreter's statement does not have to be completed unless a language other than English was used to explain the sterilization procedure to the member.

C. The method used by the Division to calculate the 30-day wait is: Begin count with the first day after the day the member signs the consent form and count forward 30 days. The sterilization may be performed as early as the 30th day.

D. The only consent form acceptable to the Division is: "Informed Consent for Voluntary Sterilization" (DMA-69) in current policy manual. No other consent form is acceptable.

E. A 30-day wait does not apply to the hysterectomy acknowledgement form. (See Appendix G.)

F. The informed consent sterilization form may not be used for hysterectomy procedures. Medically necessary hysterectomy procedures require completion of the “Patient’s Acknowledgement of Prior Receipt of Hysterectomy Information” (DMA-276, Rev 10/82) form.

A copy of the properly executed “Informed Consent for Voluntary Sterilization” form must be attached to the physician’s claim form when submitted to the Division for payment. In addition, a copy of the consent form must accompany any other claims for services rendered in conjunction with the sterilization, e.g., hospital, anesthesiology, etc. The attending physician is responsible for providing a copy of the properly executed consent form to each Medicaid provider associated with the case.

INFORMED CONSENT FOR VOLUNTARY STERILIZATION

NOTICE

YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

1. I have asked for and received information about sterilization from _____ (Physician or Clinic)
2. I have asked for the sterilization, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment and I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid, that I am not getting or for which I may become eligible.

   I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED PERMANENT AND NOT REVERSIBLE: I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN, OR FATHER CHILDREN.

3. I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father children in the future. I have rejected these alternatives and chosen to be sterilized.
4. I understand that I will be sterilized by an operation known as a _____ (Sterilization Procedure). The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.
5. I understand that the operation will not be done until at least thirty (30) days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.
6. I am at least 21 years of age and was born on _____ (Month) _____ (Day) _____ (Year)
7. I _____ (Print name of Member) hereby consent of my own free will to be sterilized by _____ (Print name of Physician) by a method called _____ (Sterilization Procedure). My consent expires 180 days from the date of my signature below.
8. I also consent to the release of this form and other medical records about the operation to: Representatives of the Department of Health, Education, and Welfare or Employees of programs funded by that Department but only for determining if Federal laws were observed.

   I have received a copy of this form.

_____ Date Signed: _____ (Month) / _____ (Day) / _____ (Year)
Signature of Medicaid Recipient

You are requested to supply the following information, but it is not required. Race and ethnicity designation (please check)
Black (not Hispanic descent) _____
Hispanic _____
Asian or Pacific Islander _____
American Indian or Alaskan Native _____
White (not of Hispanic origin) _____

INTERPRETER'S STATEMENT

I have translated the information and advice presented orally to the individual to be sterilized by the individual obtaining this consent. I have also read the consent form to _____ (Name of Member) in _____ (Language) language and explained its contents to him/her.
To the best of my knowledge and belief he/she understood this situation.

_____ Date _____ (Month) / _____ (Day) / _____ (Year)
Signature of Interpreter

IN ORDER FOR THIS FORM TO BE VALID BOTH SIDES MUST BE COMPLETED

DMA-69 (04/03) (Refer to Reverse Side)

FOR FISCAL AGENT USE ONLY

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed this consent form, I explained to him/her the nature of the
Name Of Member
sterilization operation, _____ , the fact that it is intended to be a final and
Sterilization Procedure
irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
Signature Of Person Obtaining Consent

_____
Date

_____
Facility

_____
Address

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____ on
Name of Member
_____ , I explained to him/her the nature of the sterilization operation
Date Of Operation
_____ , the fact that it is intended to be a final and irreversible procedure and
Sterilization Procedure
the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

SELECT THE APPROPRIATE PARAGRAPH: NUMBER (1) OR NUMBER (2)
(Cross out the paragraph which is not used.)

Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used.

(1) At least 30 days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

☐ Premature delivery
Individual's date of expected delivery _____

☐ Emergency abdominal surgery (describe circumstances): _____

_____

_____

Physician's Signature _____ Date _____

DMA-69 (04/03)

APPENDIX G

HYSTERECTOMIES

The Division will make reimbursement only for those hysterectomy procedures which meet the criteria established in Section 904.1 (b) of this manual.

A copy of the "Patient's Acknowledgement of Prior Receipt of Hysterectomy Information" (Form DMA 276, (Rev 10/82)) is shown on Page G-2 of this Appendix. This form must be signed, either before or after the hysterectomy, as follows and must be attached to the claim form submitted to the Division for payment.

Section I - Member's Statement

The member or her representative must sign and date this form in the spaces provided unless the member was sterile prior to the hysterectomy or the hysterectomy was an emergency**.**

Section II - Physician's Statement

The physician must sign and date this form on all hysterectomies performed. If the member was sterile prior to the hysterectomy, the physician must indicate this condition beside #1 and state the reason for prior sterility. If the hysterectomy was an emergency, the physician must indicate this condition beside #2 and attach the discharge summary and operative record.

In addition, a copy of the acknowledgement form must accompany any other claims for services rendered in conjunction with the hysterectomy, e.g., hospital, anesthesiology, etc. The attending physician is responsible for providing a copy of the properly signed acknowledgement form to each Medicaid provider associated with the case.

MEMBER INFORMATION (DMA-276)

GEORGIA DIVISION OF MEDICAID

MEDICAID PROGRAM

GEORGIA DIVISION OF MEDICAL ASSISTANCE

Medicaid Program

This is a Federally mandated form that must accompany all claims for hysterectomy.

MEMBER INFORMATION

MEMBER NAME: LAST | FIRST | INITIAL | SUFFIX

MEMBER MEDICAID CASE NO.

PATIENT'S ACKNOWLEDGEMENT OF PRIOR RECEIPT OF HYSTERECTOMY INFORMATION

Section I — Member's Statement

I have been told and I understand that this hysterectomy (operation to remove my womb/uterus) will cause/has caused me to be permanently sterile (unable to bear children).

Signature of Medicaid Member _____ Date _____

OR

Signature of Member's Representative _____ Date _____

STATEMENT OF MEDICAL NECESSITY

Section II — Physician's Statement

The above mentioned hysterectomy will be/has been performed for medical necessity, not for sterilization, hygiene purposes or mental retardation.

Check one of the below **if applicable** — (Member's signature not required if number 1 or 2 is applicable.)

1 Member was sterile prior to hysterectomy. The member was sterile because _____

_____

_____

2 Emergency Hysterectomy: (Attach a copy of the discharge summary and operative record to validate the emergency hysterectomy.)

Physician's Name (Please print) _____

Physician's Signature _____ Date _____

DMA-276 (3/03) 746-276 (ATT 05)

APPENDIX H

ABORTIONS

The Division will make reimbursement only for those abortions which meet the criteria established in Section 904.2 of this Manual.

A “Certification of Necessity for Abortion” (Form DMA-311) must be properly completed and signed for all abortions. A copy of the form must be attached to the physician’s claim when submitted to the Division for payment. In addition, a copy of the certification must accompany any other claim for services rendered in conjunction with the abortion, e.g., hospital, anesthesiology, etc. The attending physician is responsible for providing a copy of the properly executed certification form to each Medicaid provider associated with the case.

CERTIFICATE OF NECESSITY FOR ABORTION (DMA-311)

This is a federal mandated form that must be completed and attached to all invoices containing claim lines submitted for reimbursement for abortion procedures and abortion-related procedures.

The Department will reimburse *only f*or abortions which meet the criteria established in Part II, Chapter 900 of the *Policies and Procedures for Physician Services* Manual.

GEORGIA DEPARTMENT OF MEDICAL ASSISTANCE

CERTIFICATION OF NECESSITY FOR ABORTION

THE INFORMATION PROVIDED ON THIS FORM IS CONFIDENTIAL UNDER FEDERAL LAW AND REGULATIONS AND CANNOT BE DISCLOSED WITHOUT THE INFORMED CONSENT OF THE MEMBER.

MEMBER INFORMATION

NAME: _____

MEDICAID #: _____

ADDRESS: _____

_____

STATEMENT OF MEDICAL NECESSITY

This is to certify that I am a duly licensed physician and that in my professional judgment, an abortion is medically necessary for the reason indicated below:

☐ This patient suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself that would place this woman in danger of death unless an abortion is performed.

☐ Fetal Demise

☐ The pregnancy is the result of rape.

☐ The pregnancy is the result of incest.

NOTE: Please attach all supporting medical documentation.

_____, MD
(Print Name)

_____, MD
(Signature of Physician)

DMA-311 (Rev. 07/15)

APPENDIX J

NEWBORN CERTIFICATION - TEMPORARY ENROLLMENT

SUMMARY OF NEWBORN ELIGIBILITY

Effective July 1, 1995, a new process was implemented to expedite the enrollment of Medicaid eligible newborns. This process enables authorized providers to immediately obtain a temporary Medicaid number for a newborn infant, born to a Medicaid eligible mother with a Medicaid number ending with a P or S only.

Any Physician, Nurse Midwife, Nurse Practitioner, Health Check Provider, Pharmacy, Hospital, Health Department, Durable Medical Equipment Provider, or Birthing Center enrolled as a Georgia Medicaid Provider is authorized to obtain a temporary Medicaid number for these newborn infants. The authorized provider must complete a Newborn Medicaid Certification form, DMA-550, and contact DXC Technology Inquiry Unit at 1-800-766-4456 to obtain the temporary Medicaid number. Calls may be made between 8:00 a.m. and 9:00 p.m. Monday through Friday and between 9:00 a.m. and 3:00 p.m. on weekends.

The newborn Medicaid certification form will serve as a temporary Medicaid card pending issuance of a permanent card. The temporary card will be valid for a thirty-day period, beginning with the date of issuance of the number for the newborn Medicaid certification.

APPENDIX K

PROCEDURE CODES SUBJECT TO THE SITE OF SERVICE DIFFERENTIAL

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
10021	11055	11420	11621	11772	12018	13120	15110
10030	11056	11421	11622	11900	12020	13121	15111
10035	11057	11422	11623	11901	12021	13122	15115
10036		11423	11624	11920	12031	13131	15116
10040		11424	11626	11921	12032	13132	15120
10060	11200	11426	11640	11922	12034	13133	15121
10061	11201	11440	11641	11950	12035	13151	15130
10080	11300	11441	11642	11951	12036	13152	15131
10081	11301	11442	11643	11952	12037	13153	15135
10120	11302	11443	11644	11954	12041	14000	15136
10121	11303	11444	11646	11971	12042	14001	15150
10140	11305	11446	11719	11976	12044	14020	15151
10160	11306	11450	11720	11980	12045	14021	15152
10180	11307	11451	11721	12001	12046	14040	15155
11000	11308	11462	11730	12002	12047	14041	15156
11001	11310	11463	11732	12004	12051	14060	15157
11010	11311	11470	11740	12005	12052	14061	15170
11011	11312	11471	11750	12006	12053	14300	15200
11012	11313	11600	11752	12007	12054	15002	15201
11042	11400	11601	11755	12011	12055	+15003	15220
11043	11401	11602	11760	12013	12056	15004	15221
11044	11402	11603	11762	12014	12057	15040	15240
11045	11403	11604	11765	12015	13100	15050	15241
11046	11404	11606	11770	12016	13101	15100	15260
11047	11406	11620	11771	12017	13102	15101	15261

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
15271	15783	17111	19001	19030	19396	20615	21084
15272	15786	17250	19020	19081		20650	21085
15273	15787	17260	19030	19082	20100	20665	21086
15274	15788	17261	19081	19083	20101	20670	21087
15275	15789	17262	19082	19084	20102	20694	21100
15276	15792	17263	19083	19085	20103	20900	21110
15277	15820	17264	19084	19086	20200	20910	21116
15278	15821	17266	19085	19100	20205	20922	21120
15570	15822	17270	19086	19101	20206	20974	21121
15572	15823	17271	19100	19110	20220	20979	21125
15574	15837	17272	19101	19112	20225	20983	21127
15576	15839	17273	19110	19120	20500	21025	21208
15600	15851	17274	19112	19125	20501	21026	21209
15610	15852	17276	19120	19281	20520	21029	21210
15620	15860	17280	19125	19282	20525	21030	21215
15630	16000	17281	17306	19283	20550	21031	21235
15650	16020	17282	17307	19284	20551	21032	21245
15730	16025	17283	17310	19285	20552	21034	21246
15731	16030	17284	17311	19286	20553	21040	21248
15740	17000	17286	+17312	19287	20600	21076	21249
15760	17003	17311	+17314	19288	20604	21077	21270
15775	17004	+17312	17340	19296	20605	21079	21300
15776	17106	+17314	17360	19298	20606	21080	21310
15780	17107	17340	19000	19300	20610	21081	21315
15781	17108	17360	19001	19350	26011	21082	21320
15782	17110	19000	19020	19355	20612	21083	21337

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
21345	22015	23675	25500	26341	27220	27619	27818
21355	22305	23930	25505	26432	27230	27630	27824
21400	22310	23931	22510	26600	27246	27648	27825
21401	22505	24065	22511	26605	27301	27656	27830
21421	23000	24066	22512	26641	27323	27658	28001
21440	23030	24075	22513	26645	27327	27659	28002
21445	23031	24200	22514	26670		27664	28003
21450	23065	24201	22515	26675	27372	27665	28008
21451	23066	24220	25520	26700	27500	27685	28010
21452	23075	24362	25530	26705	27501	27686	28011
21453	23330	24500	25535	26720	27508	27730	28020
21461	23350	24505	25560	26725	27516	27732	28022
21462	23500	24530	25565	26740	27517	27740	28024
21480	23505	24535	25600	26742	27520	27742	28035
21485	23520	24560	25605	26750	27530	27750	28043
21497	23525	24565	25622	26755	27532	27752	28045
21501	23540	24576	25624	26770	27538	27760	28046
21550	23545	24577	25630	26775	27550	27762	28050
21555	23570	24600	25635	26991	27560	27780	28052
21700	23575	24640	25650	27040	27603	27781	28054
21720	23600	24650	25675	27047	27604	27786	28060
21820	23605	24655	26010	27086	27605	27788	28062
21920	23620	24670	26011	27093	27606		28070
21925	23625	24675	26055	27095	27613	27808	28072
21930	23650	25065	26070	27096	27614	27810	28080
22010	23665	25246	26160	27200	27618	27816	28086

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
28088	28190	28291	28435	28645	29125	29550	30801
28090	28192	28292	28450	28660	29126	29581	30802
28092	28193	28295	28455	28665	29130	29582	30901
28100	28200	28296	28470	28666	29131	29583	30903
28103	28202	28297	28475	28675	29200	29584	30905
28104	28208	28298	28490	28740	29220	29580	30906
28107	28210	28299	28495	28750	29240	29700	31000
28108	28220	28300	28496	28755	29260	29705	31002
28110	28222	28302	28505	28760	29280	29710	31020
28111	28225	28304	28510	28820	29305	29720	31030
28112	28230	28305	28515	28825	29325	29730	31231
28113	28232	28306	28525	28890	29345	29740	31233
28114	28234	28307	28530	29000	29355	29750	31235
28116	28238	28308	28531	29010	29358	29850	31237
28118	28240	28310	28540	29015	29365	30000	31238
28119	28250	28312	28546	29035	29405	30020	31295
28120	28260	28313	28555	29040	29425	30100	31296
28122	28261	28315	28570	29044	29435	30110	31297
28124	28262	28322	28575	29046	29440	30117	31298
28126	28270	28340	28576	29049	29445	30124	31502
28140	28272	28341	28585	29055	29450	30200	31505
28150	28280	28344	28600	29058	29505	30210	31510
28153	28285	28345	28606	29065	29515	30220	31511
28160	28286	28400	28630	29075	29520	30300	31512
28173	28288	28405	28635	29085	29530	30560	31515
28175	28289	28430	28636	29105	29540	30580	31525

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
31570	32405	36400	36554	37223	37253	40810	41251
31572	32503	36405	36556	37224	37609	40812	41252
31573	32504	36406	36589	37225	37718	40814	41800
31574	32960	36410	36598	37226	37722	40816	41806
31575	32994	36425	36600	37227	37785	40819	41822
31576	32998	36430	36860	37228	38220	40820	41823
31577	33011	36450	36901	37229	38221	40830	41825
31578	33507	36465	36902	37230	38222	40844	41826
31579	33548	36466	36903	37231	38300	41000	41827
31612	33768	36470	36904	37232	38305	41005	41828
31615	33880	36471	36905	37233	38500	41006	41830
31622	33881	36473	36906	37234	38505	41007	41874
31623	33883	36474	36907	37235	38790	41008	42000
31624	33884	36475	36908	37236	40490	41009	42100
31625	33886	36476	36909	37237	40500	41015	42104
31628	33889	36478	37184	37238	40510	41016	42106
31634	33891	36479	37185	37239	40520	41017	42107
31652	33925	36482	37186	37241	40530	41018	42140
31653	33926	36483	37187	37242	40650	41100	42145
31654	33967	36489	37191	37243	40652	41105	42160
31700	36000	36510	37192	37244	40654	41108	42180
31717	36005	36522	37193	37246	40800	41110	42182
31720	36251	36533	37188	37247	40801	41112	42280
31730	36252	36535	37220	37248	40804	41113	42281
31825	36253	36536	37221	37249	40805	41115	42300
32400	36254	36537	37222	37252	40808	41250	42310

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
42320	43201	44187	45331	46200	46910	47544	50551
42325	43202	44188	45332	46210	46916	48102	50553
42326	43210	44213	45333	46211	46917	49000	50555
42330	43211	44227	45335	46220	46922	49082	50557
42335	43212	44385	45338	46221	46924	49083	50561
42340	43213	44386	45340	46230	46937	49180	50590
42400	43229	44388	45378	46250	46938	49185	50592
42405	43235	44389	45379	46255	46940	49405	50606
42450	43236	44390	45380	46270	46942	49406	50684
42550	43239	44391	45381	46275	46945	49407	50686
42600	43210	44392	45382	46285	46946	49418	50690
42650	43212	44394	45384	46320	47000	49452	50693
42660	43245	45005	45385	46500	47383	49465	50694
42665	43270	45100	45395	46505	47531	49505	50695
42700	43450	45108	45397	46600	47532	50250	50705
42720		45150	45400	46604	47533	50382	50706
42800	43770	45300	45402	46606	47534	50384	50951
42802	43771	45303	45520	46608	47535	50387	50953
42804	43772	45305	45910	46610	47536	50389	50955
42806	43773	45307	45915	46611	47537	50391	50957
42808	43774	45308	46020	46612	47538	50430	50961
42809	43886	45309	46030	46614	47539	50431	51600
42810	43887	45315	46040	46615	47540	50432	51605
43197	43888	45317	46050	46710	47541	50433	51610
43198	44180	45320	46080	46712	47542	50434	51700
43200	44186	45330	46083	46900	47543	50435	51701

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
51702	52330	54055	56405	57415	58350	60100	62325
51703	52332	54056	56420	57420	58353	61000	62326
51705	52441	54057	56440	57421	58356	61001	62327
51710	52442	54060	56441	57452	58555	61020	62369
51715	52647	54065	56501	57454	58558	61026	62370
51720	53000	54100	56515	57455	58563	61070	64400
52000	53020	54105	56605	57456	58565	62263	64402
52005	53025	54115	56606	57460	58800	62264	64405
52010	53040	54150	56700	57461	58970	62270	64408
52204	53060	54160	56720	57500	58976	62272	64410
52214	53200	54200	56740	57505	59000	62273	64413
52224	53260	54220	56820	57510	59015	62280	64415
52234	53265	54230	56821	57511	59160	62281	64417
52235	53270	54231	57020	57513	59200	62282	64418
52240	53600	54235	57061	57520	59300	62284	64420
52265	53601	54450	57065	57522	59412	62290	64421
52270	53620	54500	57100	57558	59425	62291	64425
52275	53621	54700	57105	57800	59426	62302	64430
52276	53660	54800	57135	58100	59430	62303	64435
52281	53661	55000	57150	58110	59812	62304	64445
52282	53850	55100	57156	58120	59820	62305	64461
52283	53852	55250	57160	58301	59821	62320	64462
52285	54000	55700	57170	58321	59840	62321	64463
52310	54001	55870	57180	58322	59841	62322	64470
52315	54015	55874	57295	58323	59871	62323	64472
52317	54050	55876	57410	58340	60000	62324	64479

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
64480	64611	65220	66130	67345	67916	68530	69540
64483	64613	65222	66250	67500	67917	68705	69610
64484	64614	65270	66625	67505	67921	68760	69620
64486	64616	65272	66700	67515	67922	68761	90837
64487	64617	65275	66710	67700	67923	68770	90845
64488	64620	65286	66720	67710	67924	68801	90846
64489	64627	65400	66761	67800	67930	68810	90847
64490	64630	65410	66762	67801	67935	68815	90849
64491	64633	65420	66770	67805	67938	68840	90853
64492	64634	65426	66821	67810	67950	68850	90862
64494	64635	65430	67025	67820	67961	69000	90865
64495	64636	65435	67027	67825	67966	69005	90880
64505	64640	65436	67028	67830	68020	69020	90911
	64642	65450	67031	67840	68040	69100	91022
64510	64643	65600	67101	67850	68100	69105	91117
64520	64344	65772	67105	67875	68110	69110	92002
64530	64645	65778	67110	67880	68115	69145	92004
64550	64646	65779	67120	67882	68135	69200	92012
64553	64647	65785	67141	67900	68200	69210	92014
64555	64650	65800	67145	67903	68330	69220	92019
64561	64653	65805	67208	67904	68340	69222	92020
64566	64680	65815	67210	67906	68360	69410	92071
64585	64721	65855	67220	67908	68400	69420	92072
64600	65125	65860	67221	67909	68420	69421	92100
64605	65205	66020	67227	67914	68440	69424	92120
64612	65210	66030	67228	67915	68510	69433	92130

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
92140	92577	95146	95874	96446	98927	99292	99347
92225	92582	95147	95874	96450	98928	99301	99348
92226	92612	95148	95970	96521	98929	99302	99349
92230	92950	95149	95971	96522	98940	99303	99350
92260	92960	95165	95972	96523	98941	99304	99354
92287	93313	95170	95973	96542	98942	99305	99355
92311	93316	95180	95978	96570	99151	99306	
92312	93566	95251	95979	96571	99152	99307	
92313	93567	95830		97014	99170	99308	
92315	93568	95831		97016	99183	99309	
92316	93720	95832		97018	99201	99310	
92317	93721	95833	96116	97026	99202	99318	
92330	93722	95834	96118	97028	99203	99324	
92335	93797	95851	96119	97032	99204	99325	
92504	93798	95852	96120	97033	99205	99326	
92506	94640	95857	96401	97034	99211	99327	
92507	94660	95865	96402	97036	99212	99328	
92508	94664	95865	96405	97039	99213	99334	
92511	94667	95865	96406	97113	99214	99335	
92512	94668	95866	96409	97116	99215	99336	
92516	94780	95866	96411	97150	99241	99337	
92520	94781	95866	96413	97533	99242	99341	
92565	95056	95873	96415	97750	99243	99342	
92571	95065	95873	96416	97770	99244	99343	
92575	95144	95873	96417	98925	99245	99344	
92576	95145	95874	96440	98926	99291	99345	

APPENDIX L
Radiology Services requiring Prior Authorization

CODE	DESCRIPTION
47531	Injection of bile duct for x-ray imaging procedure, include radiological imaging guidance
47532	Injection of bile duct for x-ray imaging procedure, new access, radiological imaging guidance
47533	Placement of drainage catheter of biliary duct, percutaneous, radiological imaging guidance
47534	Placement of drainage catheter of biliary duct, percutaneous, radiological imaging, internal-external
47535	Conversion of external biliary drainage catheter to internal-external biliary drainage catheter
47536	Replacement of liver duct drainage catheter, percutaneous, with radiological imaging and interpretation
47537	Removal of biliary drainage catheter, percutaneous, with radiological imaging and interpretation
47538	Placement of stent into a bile duct, percutaneous, including radiological imaging guidance
47539	Placement of new access, without placement of separate biliary drainage catheter
47540	Placement of new access, with placement of separate biliary drainage catheter
47541	Placement of access through the biliary tree and into small bowel to assist endoscopic biliary procedure
47542	Balloon dilation of biliary duct(s) or of ampulla, percutaneous, radiological imaging guidance
47543	Endoluminal biopsy of biliary tree, percutaneous, any methods, radiological imaging guidance
47544	Removal of calculi/debris from biliary duct(s) and/or gallbladder, percutaneous
50430	Injection for x-ray imaging of kidney and urinary duct (ureter), radiological imaging guidance
50431	Injection for x-ray imaging of kidney and urinary duct, existing access
50432	Placement of catheter of kidney, percutaneous, including radiological imaging guidance
50433	Placement of nephroureteral catheter, percutaneous, including radiological imaging guidance
50434	Convert nephrostomy catheter to nephroureteral catheter, percutaneous, radiological imaging guidance
50435	Replacement of kidney drainage catheter, percutaneous, including radiological imaging guidance
50693	Placement of stent of urinary duct (ureter), percutaneous, including radiological imaging guidance

APPENDIX L
Radiology Services requiring Prior Authorization

50694	Placement of stent of urinary duct (ureter), new access, without separate nephrostomy catheter
50695	Placement of stent of urinary duct (ureter), new access, with separate nephrostomy catheter
50705	Ureteral embolization or occlusion, including radiological imaging guidance
50706	Ballon dilation, ureteral stricture, including radiological imaging guidance
70450	CT Head/Brain wo Dye
70460	CT Head/Brain w Dye
70470	CT Head/Brain wo & w Dye
70551	MRI Brain wo Dye
70552	MRI Brain w Dye
70553	MRI Brain wo & w Dye
72148	MRI Lumbar Spine wo Dye
72149	MRI Lumbar Spine w Dye
72158	MRI Lumbar Spine wo & w Dye
72192	CT Pelvis wo Dye
72193	CT Pelvis w Dye
72194	CT Pelvis wo & w Dye
74150	CT Abdomen wo Dye
74160	CT Abdomen w Dye
74170	CT Abdomen wo & w Dye
74176	CT Abdomen & Pelvis wo contrast
74177	CT Abdomen & Pelvis w contrast
74178	CT Abdomen & Pelvis 1+ Section/Regns
76801	OB US<14 weeks, Single Fetus
76802	OB US<14 weeks, Addl Fetus
76811	OB US, Detailed , Single Fetus

APPENDIX L
Radiology Services requiring Prior Authorization

76813 OB US, Nuchal Meas, 1 GEST

76814 OB US, Nuchal Meas, Add-on

76815 OB US, Limited, Fetus(s)

76816 OB US, Follow-up, per Fetus

76817 OB US, w/image documentation, trans-vaginal

78608 PET Brain Imaging

78811 PET Tumor Imaging limited area

78812 PET Tumor Imaging skull to thigh

78813 PET Tumor Imaging whole body

78814 PET w/CT imaging limited area

78815 PET with CT imaging skull to thigh

78816 PET with CT imaging whole body

Note: Prior authorization for the below listed pregnancy related ultrasounds is required after the first ultrasound (76805 and 76817) or in some cases, prior to rendering the service.

76805 OB US>/=14 weeks, Single Fetus

76810 OB US>/=14 weeks, Addl Fetus

76812 OB US, Detailed, Addl Fetus

76817 OB US, w/image documentation, transvaginal

Note: Changes for Radiology and Cardiology Services that require Prior Authorization (not limited to MRIs, CTs and similar procedures)

Effective October 1, 2014, Georgia Medicaid is expanding its list of radiology codes for medical services that require Prior Authorization (PA) for Medicaid Fee-for-Service members. If a member's medical condition warrants immediate care utilizing a service that requires a PA, a provider can submit an emergency waiver of the PA to Alliant Health Solutions by providing the appropriate supporting clinical documentation. The PA processes for the additional PA radiology requests are the same as the current (other) PA requests. Please allow Alliant Health Solutions up to 10 business days for review and response to your PA request via your Provider Workspace logon on the DXC Technology web portal at www.mmis.georgia.gov. The 53 additional procedure HCPCS/CPT codes fall within the radiology and cardiology areas of service. Below is the list of affected radiology codes that will require a PA with dates of service on or after October 1, 2014:

APPENDIX L
Radiology Services requiring Prior Authorization

72141 - MRI NK SP W/O DYE

72142 - MRI NK SP W/DYE

72146 - MRI CH SP W/O DYE

72147 - MRI CH SP W/DYE

72156 - MRI NK SP W/O & W/DYE

72157 - MRI CH SP W/O & W/DYE

70540 - MRI ORBIT/FACE/NECK W/O DYE

70542 - MRI ORBIT/FACE/NECK W/DYE

70543 - MRI ORBT/FACE/NECK W/O &W/DYE

70559 - MRI BRAIN W/O & W/DYE

71550 - MRI CHEST W/O DYE

71551 - MRI CHEST W/DYE

71552 - MRI CHEST W/O & W/DYE

71555 - MRI ANGIO CHEST W & W/O DYE

72195 - MRI PELVIS W/O DYE

72196 - MRI PELVIS W/DYE

72197 - MRI PELVIS W/O & W/DYE

73218 - MRI UPPER EXTREM W/O DYE

73219 - MRI UPPER EXTREM W/DYE

73220 - MRI UPPR EXTREM W/O & W/DYE

73221 - MRI JOINT UPR EXTREM W/O DYE

73222 - MRI JOINT UPR EXTREM W/DYE

73718 - MRI LOWER EXTREM W/O DYE

73719 - MRI LOWER EXTREM W/DYE

73223 - MRI JOINT UPR EXTREM W/O&W/DYE

73718 - MRI LOWER EXTREM W/O DYE

73719 - MRI LOWER EXTREM W/DYE

73720 - MRI LOWER EXTREM W/O & W/DYE

73721 - MRI JNT OF LOWER EXTRM W/O DYE

73222 - MRI JOINT UPR EXTREM W/DYE

APPENDIX L
Radiology Services requiring Prior Authorization

73223 - MRI JOINT UPR EXTREM W/O&W/DYE

73718 - MRI LOWER EXTREM W/O DYE

73719 - MRI LOWER EXTREM W/DYE

73720 - MRI LOWER EXTREM W/O & W/DYE

73721 - MRI JNT OF LOWER EXTRM W/O DYE

73722 - MRI JOINT OF LOWER EXTREM W/DYE

73723 - MRI JNT LOWER EXTREM W/O & W/DYE

74176 - CT ABD & PELVIS W/O DYE

74181 - MRI ABDOMEN W/O DYE

74182 - MRI ABDOMEN W/DYE

74183 - MRI ABDOMEN W/O & W/DYE

74185 - MRI ANGIO ABDOMEN W/ OR W/O DYE

75557 - CARDIAC MRI FOR MORPH

75561 - CARDIAC MRI FOR MORPH W/O DYE

75563 - CARD MRI W/STRESS IMAGING

75565 - CARD MRI VELOCITY FLOW IMAGING

77065 – DIAGNOSTIC MAMMOGRAPHY

77066 - DIANOSTIC MAMMOGRAPHY BILATERAL

77067- SCREENING MAMMOGRAPHY (BILATERAL)

77059 - MRI BOTH BREASTS

76705 - ECHO EXAM OF ABDOMEN

76830 - TRANSVAG US NON-OB

71260 - CT THORAX W/DYE

78451 - MYOCARDIAL IMAGING - SINGLE

78452 - MYOCARDIAL IMAGING - MULTI

78453 - MYOCARDIAL IMAGING

78454 - MYOCARDIAL IMAGING

78466 - MYOCARDIAL IMAGING

93303 - TTE – INITIAL

93304 - TTE – FOLLOW-UP

APPENDIX L
Radiology Services requiring Prior Authorization

93306 - TTE - 2D COLOR

93307 - TTE - 2D COLOR/SPECTRAL

93308 - TTE - 2D COLOR FOLLOW-UP

This is a policy adjustment being made by Georgia Medicaid to the scope of certain radiology procedures codes that will now require prior authorization. Claims submitted for the affected radiology procedure codes rendered on or after October 1, 2014, without prior authorization will not be paid.

APPENDIX M

Change in Publication of "V" Codes Available

Effective October 1, 2004, the Department will no longer publish "V" codes available for utilization within Georgia Medicaid. Utilization must be based upon correct coding guidelines and follow program policy.

APPENDIX N

PHYSICIAN'S CERTIFICATION OF

MEDICAL EVALUATION OF HEARING LOSS

Medical Clearance for Hearing Aid Referral:

Patient Name: _____

Date: _____

The above patient has been evaluated and maybe considered a candidate for a hearing aid:

Date of Evaluation: _____

Physician's Signature: _____

Physicians Name: _____

Address: _____

APPENDIX O

OUTPATIENT HOSPITAL, INPATIENT HOSPITAL AND AMBULATORY SURGICAL CENTER PROCEDURES REQUIRING PRIOR APPROVAL/PRE-CERTIFICATION

The following CPT/HCPCS codes represent the procedures and services that must be prior approved (PA) and/or pre-certified before services are rendered in an outpatient setting, ambulatory surgical center, or hospital, except in emergencies. Emergency services must be reported and reviewed retrospectively within 30-days.

Effective with date of service on and after October 1, 2006, all services requiring prior approval and/or pre-certification applies to all eligible members, regardless of age.

Note: Prior approval (PA) for certain procedures may be completed telephonically; while others are limited to written or web portal submission only. For further information, contact the DXC Technology at (800) 766-4456 (Toll free).

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
11310	15152	15750	17284	22552	26418	27637	28072	28202
11311	15155	15756	17286	22534	26420	27638	28080	28208
11312	15157	15758	17311	22633	26426	27656	28086	28210
11313	15200	15760	17312	22634	26428	27680	28088	28220
11750	15220	15770	17313	22856	26432	27681	28090	28222
14001	15240	15840	17314	22861	26433	27685	28092	28225
14020	15260	15841	17315	22864	26434	27686	28102	28226
14021	15271	15842	19301	22900	27027	27687	28103	28230
14041	15272	15845	19302	23334	27057	27690	28107	28232
14060	15273	17260	19303	23335	27325	27691	28110	28240
14061	15274	17261	19304	26055	27326	27692	28111	28288
14300	15275	17262	19305	26060	27329	27700	28112	28340
14350	15276	17263	19306	26111	27345	27702	28113	28341
15002	15277	17264	19307	26160	27420	27703	28114	28344
15003	15278	17266	20696	26350	27422	27705	28116	28360
15004	15570	17270	20697	26352	27424	27707	28118	28810
15005	15572	17271	20975	26356	27425	27709	28119	28820
15040	15574	17272	21032	26358	27430	27712	28120	28825
15050	15576	17273	21240	26370	27435	27715	28122	29870
15100	15600	17274	21244	26372	27605	27745	28124	29871
15110	15610	17276	21247	26373	27606	27880	28126	29874
15115	15620	17280	22532	26390	27612	28008	28171	29875
15130	15630	17281	22533	26392	27620	28045	28173	29876
15135	15650	17282	22548	26410	27630	28055	28175	29877
15150	15740	17283	22551	26412	27635	28062	28200	29879

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
29880	31205	31651	34846	36226	40510	43242	43332	45378
29881	31231	31652	34847	36227	40650	43247	43333	45380
29882	31233	31653	34848	36228	40652	43249	43334	45383
29883	31235	31654	35302	36556	40654	43251	43335	45385
29884	31237	31660	35303	37197	41006	43257	43336	45391
29885	31238	31661	35304	37217	41007	43260	43337	45392
29886	31239	32851	35305	37220	41009	43262	43338	45395
29887	31240	32852	35306	37221	42145	43263	43360	45397
29888	31276	32853	35506	37222	42950	43264	43361	45400
29889	31287	32854	35535	37223	43200	43265	43775	45402
29914	31288	32998	35537	37224	43201	43273	44157	45500
29915	31290	33202	35538	37225	43213	43274	44158	45505
29916	31291	33254	35539	37226	43214	43275	44180	45520
30115	31292	33255	35540	37227	43217	43276	44186	45560
30117	31293	33256	35570	37228	43220	43277	44187	46505
30118	31294	33366	35632	37229	43226	43278	44188	47531
30125	31620	33675	35633		43231	43279	44204	47532
30150	31622	33676	35634	37230	43232	43280	44205	47533
30160	31626	33677	35637	37232	43233	43281	44206	47534
31020		34805	35638	37233	43235	43282	44208	47535
31030	31627	34841	36221	37234	43236	43324	44227	47536
31032	31634	34842	36222	37252	43238	43325	44360	47537
31070	31647	34843	36223	37253	43239	43326	44361	47538
31200	31648	34844	36224	37780	43240	43327	44364	47539
31201	31649	34845	36225	37785	43241	43328	44369	47540

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
47541	52224	52341	53447	57520	60271	63045	63272	64569
47542	52234	52342	53448	57522	60500	63046	63273	64633
47543	52235	52343	53449	57558	60502	63047	63275	64634
47562	52240	52347	53450	58120	60505	63170	63276	64635
47563	52250	52351	53460	58353	60512	63180	63277	64636
47564	52260	52352	54150	58541	60521	63182	63278	64650
48105	52270	52356	54161	58555	61586	63185	63280	64653
48548	52275	52400	54520	58558	61600	63190	63281	64681
49000	52276	52450	54522	58559	61797	63191	63282	66820
49320	52277	52500	54530	58560	61798	63194	63283	66821
49402	52281	52601	54535	58561	61799	63195	63285	66830
50382	52287	52630	54865	58562	61800	63196	63286	66840
50387	52283	52640	55040	58563	62310	63197	63287	66850
50945	52285	52647	55041	58660	62311	63198	63290	66852
50947	52290	52648	55060	58661	62318	63199	63295	66920
50948	52300	53400	55175	58662	62319	63200	63620	66930
51990	52305	53405	55180	58672	62367	63250	63621	66940
51992	52310	53410	55500	58673	63001	63251	63650	66982
52000	52315	53420	55540	60210	63003	63252	63655	66983
52001	52317	53425	55605	60212	63005	63265	63685	66984
52005	52318	53430	55650	60220	63011	63266	64415	66985
52007	52320	53431	56442	60225	63012	63267	64483	66986
52010	52330	53440	57268	60240	63015	63268	64484	67311
52204	52332	53444	57287	60260	63016	63270	64491	67312
52214	52340	53445	57425	60270	63017	63271	64568	67320

CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code	CPT Code
67331	68362	93454	99475					
67332	69110	93455	99476					
67346	69140	93456						
67808	69145	93457						
67880	76828	93458						
67882	90911	93459						
67901	91120	93460						
67914	92065	93461						
67916	92521	93503						
67917	92522	93530						
67921	92523	93531						
67923	92524	93532						
67924	93656	93533						
67950	92585	93561						
67961	92610	93562						
67966	92611	93580						
67971	92920	93653						
67973	92924	93654						
67974	92928	93655						
67975	92933	93656						
68320	92937	95970						
68325	92941	96570						
68326	93451	96571						
68328	93452	99471						
68360	93453	99472						

APPENDIX P

Drug and Pharmacy Information

For specific information regarding services, coverage, and limitations under the Pharmacy program, please see the Pharmacy Services manual, the Medicaid Preferred Drug List, and relevant Banner Messages available online at www.mmis.georgia.gov. Paper copies of the manual or Drug List may be obtained from the Division's fiscal agent by contacting the DXC Technology at 1 (800) 766-4456.

Georgia Medicaid FFS Tamper Resistant Prescription Pad (TRPP)- Prescriber Update

On October 1, 2008, the Centers for Medicare and Medicaid Services (CMS) tamper-resistant prescription law took effect requiring all handwritten and/or computer generated (by an electronic medical record (EMR) or prescribing applications) printed prescriptions for fee-for-service Medicaid patients contain at least one industry recognized feature from each of the three categories of tamper resistance.

The Georgia Department of Community Health (DCH) Office of the Inspector General Program Integrity division is required to enforce this federal requirement. Any payment made for a prescription that does not comply with this requirement will be recouped by the Department. The Center for Medicare and Medicaid Services (CMS) strongly supports both e-prescribing and the use of tamper-resistant prescription pads as methods to reduce instances of unauthorized, improperly altered, and counterfeit prescriptions.

Review of CMS Requirements for TRPP:

Required tamper-resistant characteristics include one or more industry-recognized features designed to:		Examples include but are not limited to:
1	**Prevent unauthorized copying of a completed or blank prescription form**	• High security watermark on reverse side of blank • Thermochromic ink technology • Photocopied prescription blanks show the word "Copy," "Illegal," or "Void."
2	**Prevent erasure or modification of information written on the prescription by the prescriber**	• Tamper-resistant background ink shows erasures or attempts to change written information
3	**Prevent the use of counterfeit prescription forms**	• Duplicate or triplicate blanks

Summary of features that could be used on a tamper-resistant pad/paper in compliance with the CMS guidelines

Category 1 – Copy Resistance: One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
Feature	**Description**
"Void" "Illegal" or "Copy" pantograph with or without Reverse "Rx"	The word "Void " "Illegal " or "Copy" appears when the prescription is photocopied. Except where state law mandates the word "Void" or "Illegal" – it is recommended that the pantograph show The word "Copy" if the prescription is copied. The pantograph should be placed so as not to obscure the security feature description contained on the prescription, the patient and prescriber demographics, or the medication and directions. Some pantographs can be problematic because when the Prescription is copied, the resulting "void" or other wording that appears makes the underlying prescription difficult to read. These types of pantograph should be avoided. Providers may wish to ask their pad vendor about hollow "VOID" pantograph lettering which is less likely to obscure the information. The Reverse Rx disappears when photocopied at a light setting – thus making the pantograph more effective in copy resistance. The pantograph may be used with a reverse Rx, but Reverse Rx is not effective as a feature by itself.
Micro printing – To be effective, this feature must be printed in 0.5 font or less making it illegible to the pharmacist when copied	Very small font which is legible (readable) when viewed at 5x magnification or greater, and illegible when copied.
Thermochromic ink	Ink changes color with temperature change.
Coin-reactive ink	Ink changes color when rubbed by a coin.
Watermarking Security back print (artificial watermark)	Printed on the back of prescription form. The most popular wording for the security back print is "Security Prescription" or the security back print can include the states name. Can only be seen when viewed at an angle.

Category 1 – Copy Resistance: One or more industry recognized features designed to prevent unauthorized copying of a completed or blank prescription form.	
Feature	**Description**
Digital watermarks	Weak digital watermarks cannot be read if copied and strong digital watermarks provide digital rights management/"proof" of origin when copied.
Watermarking on special paper	Special paper contains a watermark that can be seen when Backlit

Category 2 – Erasure / Modification Resistance: One or more industry-recognized features designed to prevent the erasure or modification of information written / printed on the prescription by the prescriber.	
Features to Prevent Erasure	**Description**
An erasure revealing background (erasure resistance)	Background that consists of a solid color or consistent pattern that has been printed onto the paper. This will inhibit a forger from physically erasing written or printed information on a prescription form. If someone tries to erase, the consistent background color will look altered and show the color of the underlying paper.
Toner Receptor Coating / Toner Lock or Color Lock paper (erasure resistance for computer generated prescriptions printed with a laser printer) OR Chemically reactive paper (erasure resistance for hand written prescriptions)	Special printer paper that establishes a strong bond between laser printed text and paper, making erasure obvious. **Note – this is NOT necessary for inkjet printers – as the ink from inkjet printers is absorbed into normal "bond" paper**. If exposed to chemical solvents, oxidants, acids, or alkalis that can be used to alter the prescription, the chemically reactive paper will react and leave a mark visible to the pharmacist.

Features to Prevent Modification	Description
Quantity check off boxes and refill indicator (circle or check number of refills or NR)	In addition to the written quantity on the prescription, quantities are indicated in ranges. It is recommended that ranges be in 25's with the highest being "151 and over". The range box corresponding to the quantity prescribed MUST be checked for the prescription to be valid. The refill indicator indicates the number of refills on the prescription. Refill numbers must be used to be a valid prescription.
Pre-printed language on prescription Paper Example: "Rx is void if more than XXX Rx's on paper"	Reduces ability to add medications to the prescription. Line must be completed for this feature to be valid. Computer printer paper can accommodate this feature by printing, "This space intentionally left blank" in an empty space or quadrant.
Quantity and Refill Border and Fill (this is the recommended for computer generated prescriptions)	Quantities and refill # are surrounded by special characters such as an asterisks to prevent modification, e.g. QTY **50** Value may also be expressed as text, e.g. FIFTY, (optional).

Category 3 – Counterfeit Resistance: One or more industry-recognized feature designed to prevent the use of counterfeit prescription forms.	
Feature	**Description**
Security features and descriptions listed on prescriptions – this feature is strongly recommended on all prescriptions	Complete list of the security features on the prescription paper for compliance purposes. This is strongly recommended to aid pharmacists in identification of features implemented on prescription.
Thermochromic ink	Ink changes color with temperature change.
Encoding techniques (bar codes)	Bar codes on prescription. Serial number or Batch number is

	encoded in a bar code.
Security Thread	Metal or plastic security threads embedded in paper as used in currency.

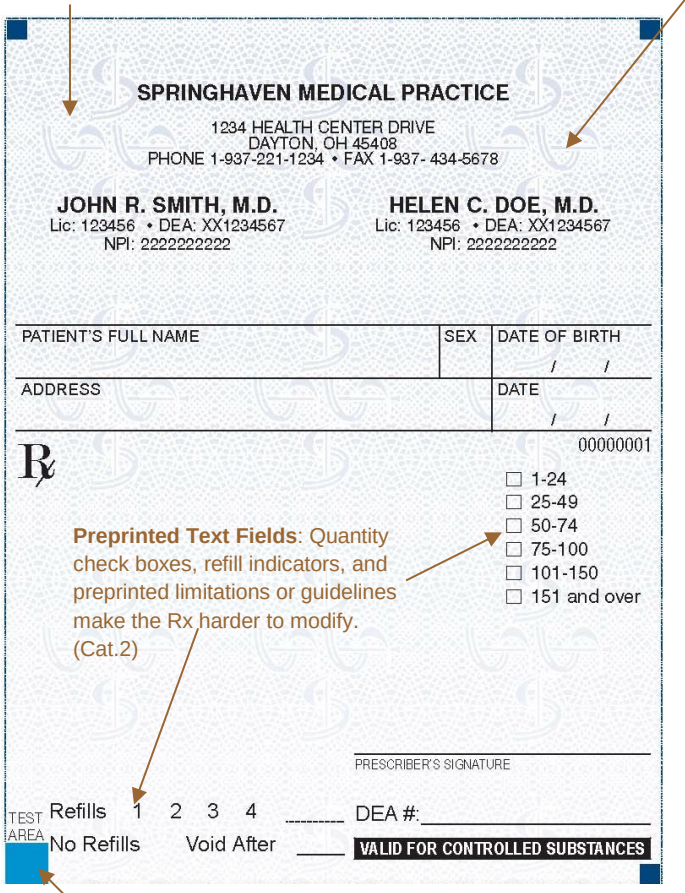
Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

Category 1	A) Photocopied "COPY", "ILLEGAL", or "VOID" Pantograph
Category 2	A) An Erasure revealing background (resists erasures and alterations) B) Quantity check off boxes C) Refill indicator (circle number of refills or "NR")
Category 3	A) Security features and descriptions listed on the prescription

Best Practices for Tamper Resistant Printed Prescriptions (Handwritten)

Front

Void or Copy Pantograph: displays "VOID" or "ILLEGAL" on a color copy of an Rx. It will appear on a wide range of copier settings. (Cat. 1)

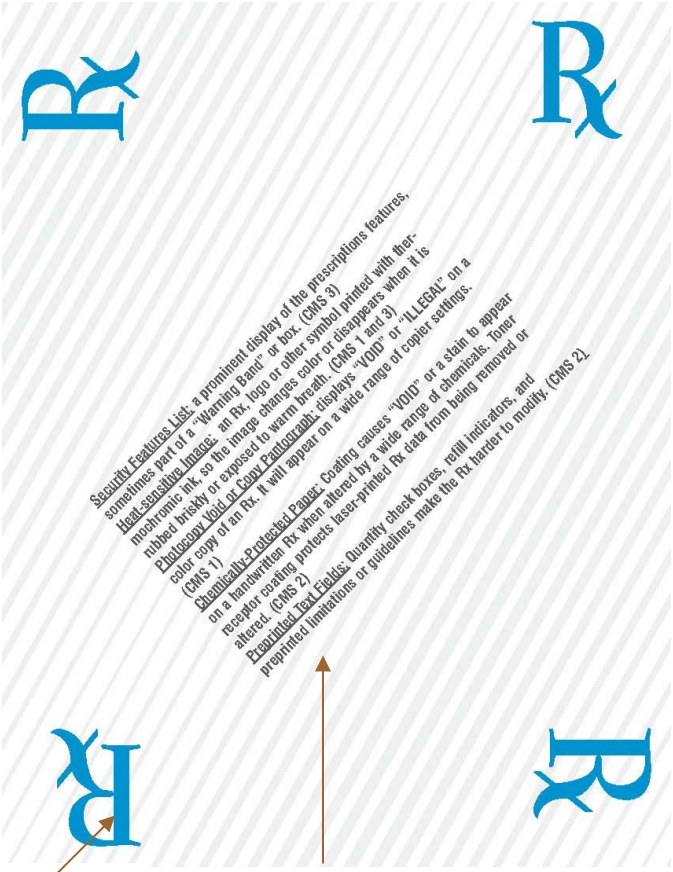


Preprinted Text Fields: Quantity check boxes, refill indicators, and preprinted limitations or guidelines make the Rx harder to modify. (Cat.2)

Heat-sensitive Image: An Rx, logo, or other symbol printed with Thermochromic ink, so the image changes color or disappears when it is rubbed briskly or exposed to warm breath. (Cat. 1 and 3)

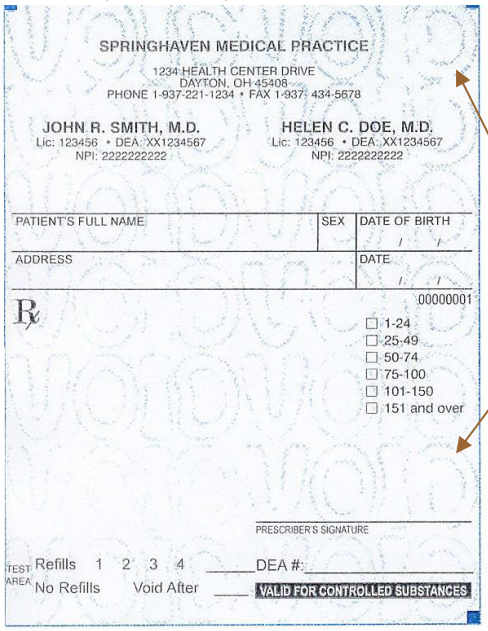
Back

Chemically-Protected Paper: Invisible coating causes "VOID" or a stain to appear on a handwritten Rx when altered by a wide range of chemicals. Toner receptor coating protects laser-printed Rx data from being removed or altered. (Cat. 2). Recommended for use with Preprinted Text Fields



Security Features List: a prominent display of the prescriptions features, sometimes part of a "Warning Band" or box. (Cat. 3)

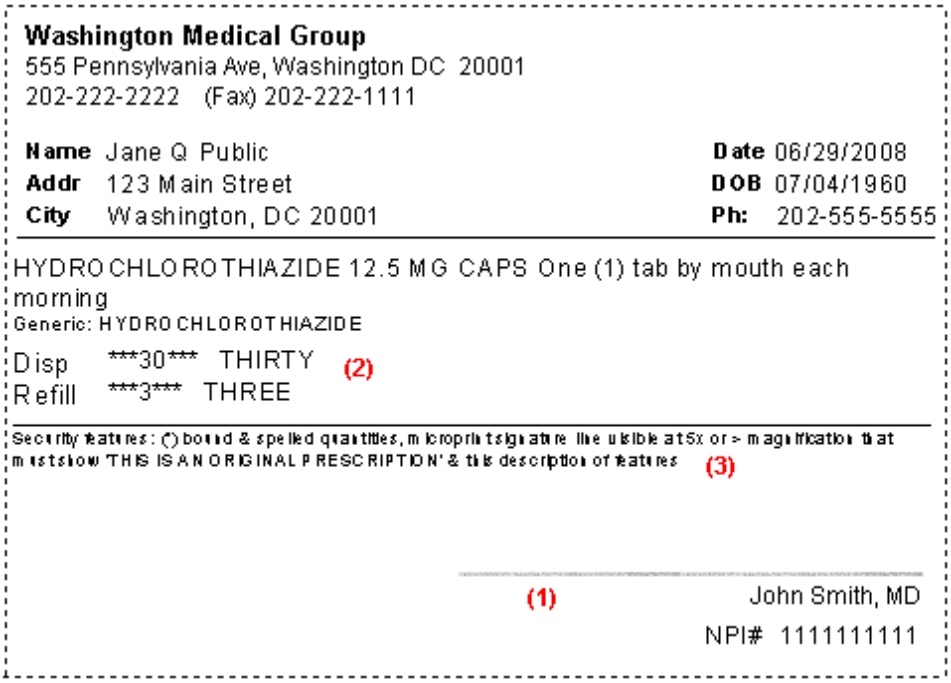
Example of a Color Copied Prescription



Hollow Pantograph: VOID or ILLEGAL is designed to not obscure or block vital information. Often showing strongest intensity at the "top" or the document. These pantographs generally do not "pop" on a black and white fax

Best Practices for Tamper Resistant Printed Prescriptions (Generated by an EMR)

Example A



Washington Medical Group
555 Pennsylvania Ave, Washington DC 20001
202-222-2222 (Fax) 202-222-1111

Name Jane Q Public
Addr 123 Main Street
City Washington, DC 20001

Date 06/29/2008
DOB 07/04/1960
Ph: 202-555-5555

HYDROCHLOROTHIAZIDE 12.5 MG CAPS One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE

Disp ***30*** THIRTY (2)
Refill ***3*** THREE

Security features: (*) bound & spelled quantities, microprint signature line visible at 5x or > magnification that must show 'THIS IS AN ORIGINAL PRESCRIPTION' & this description of features (3)

(1) John Smith, MD
NPI# 1111111111

Category #1 – Copy Resistance: Microprint signature line*

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)

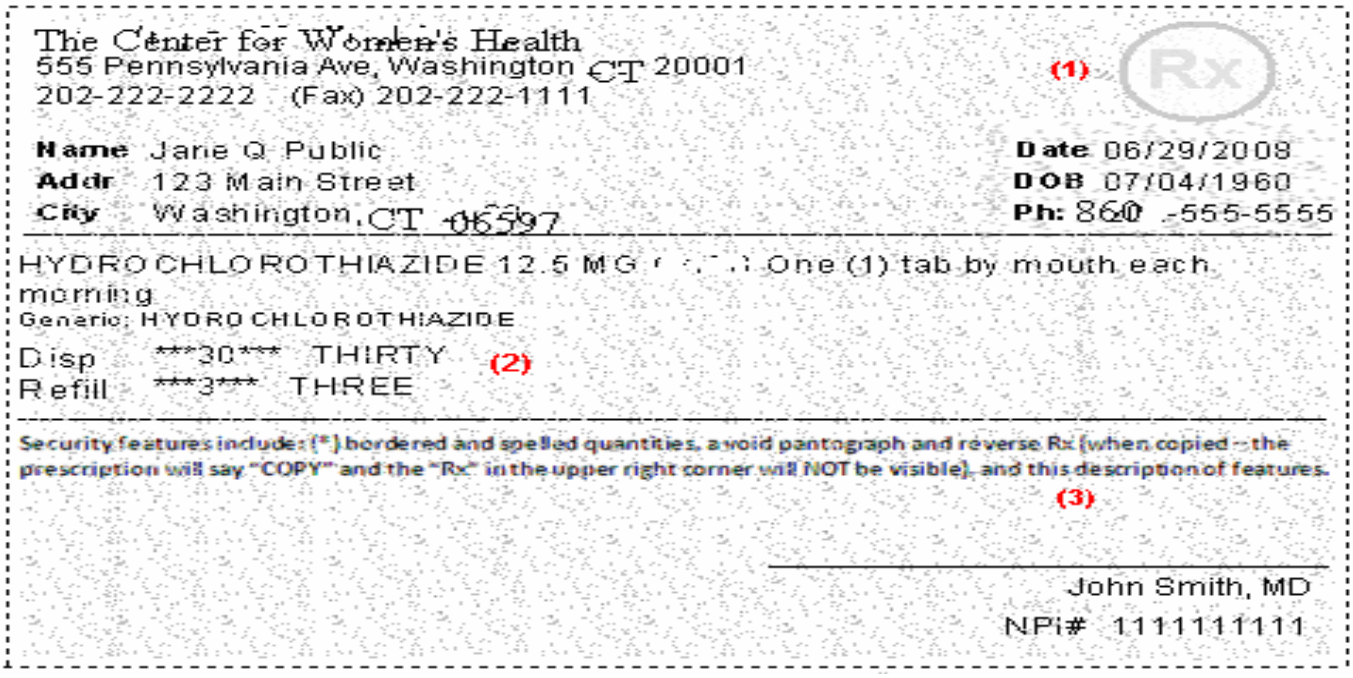
Category #2 – Modification / Erasure Resistance: Printed on "toner-lock" paper

Category #3 – Counterfeit Resistance: Listing of security features

*Microprint Line viewed at 5x magnification

THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION-THIS IS AN ORIGINAL PRESCRIPTION

Example B


The Center for Women's Health
555 Pennsylvania Ave, Washington CT 20001
202-222-2222 (Fax) 202-222-1111

(1)

Name Jane Q Public
Addr 123 Main Street
City Washington, CT 06597

Date 06/29/2008
DOB 07/04/1960
Ph: 860 -555-5555

HYDROCHLOROTHIAZIDE 12.5 MG ( ) One (1) tab by mouth each morning
Generic: HYDROCHLOROTHIAZIDE
Disp ***30*** THIRTY
Refill ***3*** THREE

(2)

Security features include: (*) bordered and spelled quantities, a void pantograph and reverse Rx (when copied -- the prescription will say "COPY" and the "Rx" in the upper right corner will NOT be visible), and this description of features.

(3)

John Smith, MD
NPi# 1111111111

Category #1 – Void/Illegal/Copy Pantograph with or without Reverse Rx

Category #2 – Modification / Erasure Resistance: Border characteristics (dispense and refill # bordered by asterisks AND spelled out)

Category #2 – Modification / Erasure Resistance: Printed on "toner-lock" paper for laser printed prescriptions, and on plain bond paper for inkjet printer prescriptions

Category #3 – Counterfeit Resistance: Listing of security features

APPENDIX Q

COPAYMENTS FOR CERTAIN SERVICES

Effective with dates of service July 1, 2005, the Division is implementing a tiered member co-payment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99201 - 99499) including the ophthalmologic services procedure codes (92002 - 92014) used by physicians or physicians' assistants.

The tiered co-payment amounts are as follows:

State's payment for the service	Maximum co-payment chargeable to members
$10.00 or less	$0.50
$10.01 to $25.00	$1.00
$25.01 to $50.00	$2.00
$50.01 or more	$3.00

The co-payment will be deducted from each evaluation and management procedure code billed unless the member is included in one of the exempted groups below.

The co-payment does not apply to the following members:

Pregnant women

Nursing facility residents

Hospice care members

Members under 21

Women diagnosed with breast or cervical cancer and receiving Medicaid under the Women's Health Medicaid Program, aid categories 245 and 800 only.

The co-payment does not apply to the following services:

Dialysis

Emergency services,

Family Planning services (must bill with medical diagnosis)

Waiver Services

The provider may not deny services to any eligible Medicaid member because of the member's inability to pay the co-payment.

The provider should check the Eligibility Certification (Medicaid card) each month in order to identify those individuals who may be responsible for the co-payment. The Eligibility Certification has been modified to include a co-payment column adjacent to the date-of-birth section. When "yes" appears in this column for a specified member, the member may be subject to the co-payment.

The Division may not be able to identify all members who are exempt from the co-payment. Therefore providers should identify the members by entering the following indicators in field 24(H) of CMS 1500 claim form:

P = Pregnant

S = Nursing facility members

H = Hospice

E = Emergency services

FP = Family Planning

DXC Technology will automatically deduct the co-payment amount from the provider's payment for claims processed with dates of service July 1, 2005 and after. Do not deduct the co-payment from your submitted charges. The application of the co-payment will be identified on the remittance advice. A new explanation of benefit (EOB) code will indicate payment has been reduced due to the application of co-payment.

Pharmacy Services

Refer to Pharmacy Service Manual for current policy and copayment requirements.

APPENDIX R

The Department of Community Health's (DCH) Telemedicine and Telehealth policies are slated to improve and increase access and efficiency to health care services by enabling medical services to be delivered via telemedicine methods in Georgia. Telemedicine services are not an expansion of Georgia Medicaid covered services; but, an option for the delivery of certain covered services. Telemedicine will allow DCH to meet the needs of members and providers, while complying with all applicable federal and state statutes and regulations. The quality of health care services delivered must be maintained regardless of the mode of delivery.

Telemedicine is the use of medical information exchange from one site to another via electronic communications to improve patients' health status. It is the use of two-way, real time interactive communication equipment to exchange the patient information from one site to another via an electronic communication system. This includes audio and video telecommunication equipment. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Telehealth is the use of telecommunication technologies for clinical care (telemedicine), patient teachings and home health, health professional education (distance learning), administrative and program planning, and other diverse aspects of a health care delivery system.

The intent of our telemedicine services policy is to improve access to essential healthcare services that may not otherwise be available for Medicaid eligible members. Telemedicine is not a separate medical specialty. Products and services related to telemedicine are often part of a larger investment by health care institutions in either information technology or the delivery of clinical care. When a provider, licensed in the state of Georgia, determines that medical care can be provided via electronic communication with no loss in the quality or efficacy of the member's care, telemedicine services can be performed. The use of a telecommunications system may substitute for an in-person encounter for professional office visits, pharmacologic management, limited office psychiatric services, limited radiological services and a limited number of other physician fee schedule services.

An interactive telecommunications system is required as a condition of payment. The originating site's system, at a minimum, must have the capability of allowing the distant site provider to visually examine the patient's entire body including body orifices (such as ear canals, nose and throat). The distant site provider should also have the capability to hear heart tones and lung sounds clearly (using a stethoscope) if medically necessary and currently within the provider's scope of practice. The telecommunication system must be secure and adequate to protect the confidentiality and integrity of the information transmitted.

For specific information regarding services, coverage, and limitations for Telemedicine Services, please see the Georgia Telemedicine Handbook, and relevant Banner Messages available online at www.mmis.georgia.gov.

APPENDIX S

Rev. Jan. 2016

PROVIDER'S GUIDE TO HIV PRE-TEST AND POST-TEST COUNSELING

All providers who provide prenatal care to pregnant women in their first trimester (before 13 weeks) are required to include voluntary HIV AIDS counseling and testing as a fundamental component of comprehensive prenatal care in order to receive the $100.00 incentive pay. Additionally, every physician and health care provider who provides prenatal care of a pregnant woman during the third trimester of gestation shall offer to test such pregnant woman for HIV and syphilis at the time of first examination during that trimester or as soon as possible thereafter, regardless of whether such testing was performed during the first two trimesters of her pregnancy. Please refer to the Independent Lab Services Manual for a list of covered procedure codes for HIV and syphilis.

HIV PRE-TEST COUNSELING

Discuss With Pregnant Women

- Prior history of HIV counseling and testing
- Nature of AIDS and HIV-related illness
- Benefits of early diagnosis and medical intervention
- HIV transmission and risk reduction behaviors
- Benefits of early diagnosis for preventing perinatal transmission and for treatment of newborn

INFORMED CONSENT FOR HIV BLOOD TEST

- Obtain written informed consent, prior to ordering test, from patient or person authorized to consent.
- Provide the patient with a copy of the consent form or document containing all pertinent information.
- Consider patient's ability, regardless of age, to comprehend the nature and consequences of HIV blood testing. If the patient's ability to understand is temporarily impaired, defer testing.
- Explain test and procedures:
  - Purpose of the test
  - Meaning of test results
  - Testing is voluntary
  - Consent may be withdrawn at any time
- Explain protections of confidential HIV-related information and conditions of authorized disclosures.
- A licensed physician or other person authorized by law to order a laboratory test must sign all orders for HIV blood testing and certify the receipt of informed consent.
- Schedule appointment for delivery of test results and post-test counseling (allow sufficient time for completion of confirmatory testing).

COMMUNICATE TEST RESULTS AND PROVIDE POST-TEST COUNSELING

Deliver test results to patient or authorized proxy in person.

For patients with <u>NEGATIVE</u> test results:

- Discuss meaning of the test results:
- Discuss possibility of HIV exposure during past six months and need to consider retesting:
- Emphasize that a negative test result does not imply immunity to future infection:
- Reinforce personal risk reduction strategies:

For Patients with <u>POSITIVE</u> Test Results:

- Discuss the meaning of the test results:
- Discuss availability of medical care including prophylaxis for opportunistic infections and antiretroviral therapy:
- Discuss and recommend use of ZVD, consistent with clinical practice guideline, to reduce risks of maternal-child transmission; discuss risk of HIV transmission through breastfeeding:
- Discuss partner/contact notification; offer assistance:
- Encourage referral of partners and children for HIV testing:
- Provide counseling or refer to counseling:
  For coping with the emotional consequences of test results
  For behavior change to prevent transmission of HIV infection
  Provide or refer to needed medical support and services:

<u>DOCUMENT THE PROVISION OF PRE/POST TEST COUNSELING AND THE TEST RESULTS IN THE PATIENT'S RECORD</u>.

MATERNAL-CHILD HIV TRANSMISSION PREVENTION COUNSELING

Counseling should explain the benefits of early diagnosis for preventing perinatal transmission and for treatment of the newborn.

Before Prescribing Any Regimen:

- Discuss with HIV-infected patient risks and benefits of antepartum, intrapartum and postpartum use of ZDV therapy to reduce the risk of maternal-child HIV transmission:
- Discuss patient concerns:
- Obtain ZDV use history:

APPENDIX T

STATEMENT OF PARTICIPATION

The new Statement of Participation

is available in the Provider Enrollment Application Package.

Written request for copies should be forwarded to:

Provider Enrollment

Access on-line at www.MMIS.georgia.gov

OR

Phone your request to:

1 (800) 766-4456

APPENDIX U

Non-Emergency Transportation

People enrolled in the Medicaid program need to get to and from health care services, but many do not have any means of transportation. The Non-Emergency Transportation Program (NET) provides a way for Medicaid recipients to get that transportation so they can receive necessary medical services covered by Medicaid.

How do I get non-emergency transportation services?

If you are a Medicaid recipient and have no other way to get to medical care or services covered by Medicaid, you can contact a transportation broker to take you. In most cases, you must call three days in advance to schedule transportation. Urgent care situations and a few other exceptions can be arranged more quickly. Each broker has a toll-free telephone number to schedule transportation services, and is available weekdays (Monday-Friday) from 7 a.m. to 6 p.m. All counties in Georgia are grouped into five regions for NET services. A NET Broker covers each region. If you need NET services, you must contact the NET Broker serving the county you live in to ask for non-emergency transportation. See the chart below to determine which broker serves your county, and call the broker's telephone number for that region.

What if I have problems with a NET broker?

The Division of Medical Assistance (DMA) monitors the quality of the services brokers provide, handling consumer complaints and requiring periodic reports from the brokers. The state Department of Audits also performs on-site evaluations of the services provided by each broker. If you have a question, comment or complaint about a broker, call the Member CIC at 866-211-0950.

REGION	Broker / Phone number	Counties served
North	Southeastern Toll free 1-866-388-9844 Local 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	Southeastern 404-209-4000	Fulton, DeKalb and Gwinnett
Central	LogistiCare Toll free 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	LogistiCare Toll free 1-888-224-7988	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	LogistiCare Toll free 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

APPENDIX V

DXC Technology

Provider Correspondence

DXC Technology

P.O. Box 105200

Atlanta, GA 30356

TUCKER, GA 30085-5201

Provider Enrollment

DXC Technology

P.O. Box 105200

Atlanta, GA 30356

Prior Authorization & Pre-Certification

Alliant Health Solutions

(Submit Prior Authorization through web portal

www.mmis.georgia.gov)

(800) 766-4456 (Toll Free)

Electronic Data Interchange (EDI)

1-800-267-8785

- Asynchronous
- Web portal
- Physical media
- Network Data Mover (NDM)
- Systems Network Architecture (SNA)
- Transmission Control Protocol/
- Internet Protocol (TCP/IP)

APPENDIX W

Georgia Families

Georgia Families® (GF) is a statewide program designed to deliver health care services to members of Medicaid, PeachCare for Kids®, and Planning for Healthy Babies® (P4HB) recipients. The program is a partnership between the Department of Community Health (DCH) and private care management organizations (CMOs). By providing a choice of health plans, Georgia Families allows members to select a health care plan that fits their needs.

It is important to note that GF is a full-risk program; this means that the four CMOs licensed in Georgia to participate in GF are responsible and accept full financial risk for providing and authorizing covered services. This also means a greater focus on case and disease management with an emphasis on preventative care to improve individual health outcomes.

The four licensed CMOs:

Amerigroup Community Care 1-800-454-3730 www.amerigroup.com	CareSource 1-855-202-1058 www.caresource.com
Peach State Health Plan 866-874-0633 www.pshpgeorgia.com	WellCare of Georgia 866-231-1821 www.wellcare.com

Children, parent/caretaker with children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families. Additionally, Planning for Healthy Babies® (P4HB) recipients receive services through Georgia Families® (GF). Children in foster care or receiving adoption assistance and certain youths committed to juvenile justice are enrolled in Georgia Families 360°.

Eligibility Categories for Georgia Families:

Included Populations	Excluded Populations
Parent/Caretaker with Children	Aged, Blind and Disabled
Transitional Medicaid	Nursing home
Pregnant Women (Right from the Start Medicaid – RSM)	Long-term care (Waivers, SOURCE)

Children (Right from the Start Medicaid – RSM)	Federally Recognized Indian Tribe
Children (newborn)	Georgia Pediatric Program (GAPP)
Women Eligible Due to Breast and Cervical Cancer	Hospice
PeachCare for Kids®	Children's Medical Services program
Parent/Caretaker with Children	Medicare Eligible
Children under 19	Supplemental Security Income (SSI) Medicaid
Women's Health Medicaid (WHM)	Medically Needy
Refugees	Recipients enrolled under group health plans
Planning for Healthy Babies®	Individuals enrolled in a Community Based Alternatives for Youths (CBAY)
Resource Mothers Outreach	

Medicaid and PeachCare for Kids® members will continue to be eligible for the same services they receive through traditional Medicaid and state Value Added Benefits. Members will not have to pay more than they paid for Medicaid co-payments or PeachCare for Kids® premiums. With a focus on health and wellness, the CMOs will provide members with health education and prevention programs giving them the tools needed to live healthier lives. Providers participating in Georgia Families will have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. **All four CMOs are State-wide.**

The Department of Community Health has contracted with four CMOs to provide these services:

- Amerigroup Community Care
- CareSource
- Peach State Health Plan
- WellCare of Georgia

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Web site at www.georgia-families.com or call 1-800-GA-ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

The following categories of eligibility are included and excluded under Georgia Families:

Included Categories of Eligibility (COE):

COE	DESCRIPTION
104	LIM – Adult
105	LIM – Child
118	LIM – 1st Yr Trans Med Ast Adult
119	LIM – 1st Yr Trans Med Ast Child
122	CS Adult 4 Month Extended
123	CS Child 4 Month Extended
135	Newborn Child
170	RSM Pregnant Women

171	RSM Child
180	P4HB Inter Pregnancy Care
181	P4HB Family Planning Only
182	P4HB ROMC - LIM
183	P4HB ROMC - ABD
194	RSM Expansion Pregnant Women
195	RSM Expansion Child < 1 Yr
196	RSM Expn Child w/DOB < = 10/1/83
197	RSM Preg Women Income < 185 FPL
245	Women's Health Medicaid
471	RSM Child
506	Refugee (DMP) – Adult
507	Refugee (DMP) – Child
508	Post Ref Extended Med – Adult
509	Post Ref Extended Med – Child
510	Refugee MAO – Adult
511	Refugee MAO – Child
571	Refugee RSM - Child
595	Refugee RSM Exp. Child < 1
596	Refugee RSM Exp Child DOB </= 10/01/83
790	Peachcare < 150% FPL
791	Peachcare 150 – 200% FPL
792	Peachcare 201 – 235% FPL
793	Peachcare > 235% FPL
835	Newborn
836	Newborn (DFACS)
871	RSM (DHACS)
876	RSM Pregnant Women (DHACS)
894	RSM Exp Pregnant Women (DHACS)
895	RSM Exp Child < 1 (DHACS)
897	RSM Pregnant Women Income > 185% FPL (DHACS)
898	RSM Child < 1 Mother has Aid = 897 (DHACS)
918	LIM Adult
919	LIM Child
920	Refugee Adult
921	Refugee Child

Excluded Categories of Eligibility (COE):

COE	DESCRIPTION
124	Standard Filing Unit – Adult
125	Standard Filing Unit – Child
131	Child Welfare Foster Care
132	State Funded Adoption Assistance
147	Family Medically Needy Spend down

148	Pregnant Women Medical Needy Spend down
172	RSM 150% Expansion
180	Interconceptional Waiver
210	Nursing Home – Aged
211	Nursing Home – Blind
212	Nursing Home – Disabled
215	30 Day Hospital – Aged
216	30 Day Hospital – Blind
217	30 Day Hospital – Disabled
218	Protected Med/1972 Cola - Aged
219	Protected Med/1972 Cola – Blind
220	Protected Med/1972 Cola - Disabled
221	Disabled Widower 1984 Cola - Aged
222	Disabled Widower 1984 Cola – Blind
223	Disabled Widower 1984 Cola – Disabled
224	Pickle - Aged
225	Pickle – Blind
226	Pickle – Disabled
227	Disabled Adult Child - Aged
227	Disabled Adult Child - Aged
229	Disabled Adult Child – Disabled
230	Disabled Widower Age 50-59 – Aged
231	Disabled Widower Age 50-59 – Blind
232	Disabled Widower Age 50-59 – Disabled
233	Widower Age 60-64 – Aged
234	Widower Age 60-64 – Blind
235	Widower Age 60-64 – Disabled
236	3 Mo. Prior Medicaid – Aged
237	3 Mo. Prior Medicaid – Blind
238	3 Mo. Prior Medicaid – Disabled
239	Abd Med. Needy Defacto – Aged
240	Abd Med. Needy Defacto – Blind
241	Abd Med. Needy Defacto – Disabled
242	Abd Med Spend down – Aged
243	Abd Med Spend down – Blind
244	Abd Med Spend down – Disabled
246	Ticket to Work
247	Disabled Child – 1996
250	Deeming Waiver
251	Independent Waiver
252	Mental Retardation Waiver
253	Laurens Co. Waiver
254	HIV Waiver
255	Cystic Fibrosis Waiver
259	Community Care Waiver
280	Hospice – Aged
281	Hospice – Blind

282	Hospice – Disabled
283	LTC Med. Needy Defacto – Aged
284	LTC Med. Needy Defacto –Blind
285	LTC Med. Needy Defacto – Disabled
286	LTC Med. Needy Spend down – Aged
287	LTC Med. Needy Spend down – Blind
288	LTC Med. Needy Spend down – Disabled
289	Institutional Hospice – Aged
290	Institutional Hospice – Blind
291	Institutional Hospice – Disabled
301	SSI – Aged
302	SSI – Blind
303	SSI – Disabled
304	SSI Appeal – Aged
305	SSI Appeal – Blind
306	SSI Appeal – Disabled
307	SSI Work Continuance – Aged
309	SSI Work Continuance – Disabled
308	SSI Work Continuance – Blind
315	SSI Zebley Child
321	SSI E02 Month – Aged
322	SSI E02 Month – Blind
323	SSI E02 Month – Disabled
387	SSI Trans. Medicaid – Aged
388	SSI Trans. Medicaid – Blind
389	SSI Trans. Medicaid – Disabled
410	Nursing Home – Aged
411	Nursing Home – Blind
412	Nursing Home – Disabled
424	Pickle – Aged
425	Pickle – Blind
426	Pickle – Disabled
427	Disabled Adult Child – Aged
428	Disabled Adult Child – Blind
429	Disabled Adult Child – Disabled
445	N07 Child
446	Widower – Aged
447	Widower – Blind
448	Widower – Disabled
460	Qualified Medicare Beneficiary
466	Spec. Low Inc. Medicare Beneficiary
575	Refugee Med. Needy Spend down
660	Qualified Medicare Beneficiary
661	Spec. Low Income Medicare Beneficiary
662	Q11 Beneficiary
663	Q12 Beneficiary
664	Qua. Working Disabled Individual

815	Aged Inmate
817	Disabled Inmate
870	Emergency Alien – Adult
873	Emergency Alien – Child
874	Pregnant Adult Inmate
915	Aged MAO
916	Blind MAO
917	Disabled MAO
983	Aged Medically Needy
984	Blind Medically Needy
985	Disabled Medically Needy

HEALTH CARE PROVIDERS

For information regarding the participating health plans (enrollment, rates, and procedures), please call the numbers listed below.

Prior to providing services, you should contact the member's health plan to verify eligibility, PCP assignment and covered benefits. You should also contact the health plan to check prior authorizations and submit claims.

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
800-454-3730 (general information) www.amerigroup.com	1-855-202-1058 www.careSource.com/GeorgiaMedicaid	866-874-0633 (general information) 866-874-0633 (claims) 800-704-1483 (medical management) www.pshpgeorgia.com	866-231-1821 www.wellcare.com

Registering immunizations with GRITS:

If you are a Vaccine for Children (VFC) provider, please continue to use the GRITS (Georgia Immunization Registry) system for all children, including those in Medicaid and PeachCare for Kids®, fee-for-service, and managed care.

Important tips for the provider to know/do when a member comes in:

Understanding the process for verifying eligibility is now more important than ever. You will need to determine if the patient is eligible for Medicaid/PeachCare for Kids® benefits and if they are enrolled in a Georgia Families health plan. Each plan sets its own medical management and referral processes. Members will have a new identification card and primary care provider assignment.

You may also contact DXC at 1-800-766-4456 (statewide) or www.mmis.georgia.gov for information on a member's health plan.

Use of the Medicaid Management Information System (MMIS) web portal:

The call center and web portal will be able to provide you information about a member's Medicaid eligibility and health plan enrollment. DXC will **not** be able to assist you with benefits, claims processing or prior approvals for members assigned to a Georgia Families health plan. You will need to contact the member's plan directly for this information.

Participating in a Georgia Families' health plan:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Credentialing

Effective August 1, 2015, Georgia's Department of Community Health (DCH) implemented a NCQA certified Centralized Credentialing Verification Process utilizing a Credentialing Verification Organization (CVO). This functionality has been added to the Georgia Medicaid Management Information System (GAMMIS) website (www.MMIS.georgia.gov) and has streamlined the time frame that it takes for a provider to be fully credentialed.

Credentialing and recredentialing services is provided for Medicaid providers enrolled in Georgia Families and/or the Georgia Families 360° program.

This streamlined process results in administrative simplification thereby preventing inconsistencies, as well as the need for a provider to be credentialed or recredentialed multiple times.

The CVO's one-source application process:

- Saves time
- Increases efficiency
- Eliminates duplication of data needed for multiple CMOs
- Shortens the time period for providers to receive credentialing and recredentialing decisions

The CVO will perform primary source verification, check federal and state databases, obtain information from Medicare's Provider Enrollment Chain Ownership System (PECOS), check required medical

malpractice insurance, confirm Drug Enforcement Agency (DEA) numbers, etc. A Credentialing Committee will render a decision regarding the provider's credentialing status. Applications that contain all required credentialing and recredentialing materials at the time of submission will receive a decision within 45 calendar days. Incomplete applications that do not contain all required credentialing documents will be returned to the provider with a request to supplement all missing materials. Incomplete applications may result in a delayed credentialing or recredentialing decision. The credentialing decision is provided to the CMOs.

HP provider reps will provide training and assistance as needed. Providers may contact HP for assistance with credentialing and recredentialing by dialing 1-800-766-4456.

Assignment of separate provider numbers by all of the health plans:

Each health plan will assign provider numbers, which will be different from the provider's Medicaid provider number and the numbers assigned by other health plans.

Billing the health plans for services provided:

For members who are in Georgia Families, you should file claims with the member's health plan.

If a claim is submitted to DXC in error:

DXC will deny the claim with a specific denial code. Prior to receiving this denial, you may go ahead and submit the claim to the member's health plan.

Receiving payment:

Claims should be submitted to the member's health plan. Each health plan has its own claims processing and you should consult the health plan about their payment procedures.

Health plans payment of clean claims:

Each health plan (and subcontractors) has its own claims processing and payment cycles. The claims processing and payment timeframes are as follows:

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Amerigroup runs claims cycles twice each week (on Monday and Thursday) for **clean** claims that have been adjudicated. Monday Claims run: Checks mailed on Tuesday. Providers enrolled in ERA/EFT	CareSource runs claims cycles twice each week on Saturdays and Tuesdays for clean claims that have been adjudicated. Pharmacy: Payment cycles for pharmacies is weekly on Wednesdays.	Peach State has two weekly claims payment cycles per week that produces payments for **clean** claims to providers on Monday and Wednesday. For further information, please refer to the Peach	WellCare runs claims payment cycles up to six (6) times each week for **clean** claims. For further information, please refer to the WellCare website, the WellCare provider manual, or contact Customer Service at 866-231-1821

receive the ACH on Thursday. Thursday Claims run: Checks mailed on Wednesday. Providers enrolled in ERA/EFT receive the ACH on Tuesday. **Dental:** Checks are mailed weekly on Thursday for **clean** claims. **Vision**: Checks are mailed weekly on Wednesday for **clean** claims (beginning June 7th) **Pharmacy**: Checks are mailed to pharmacies weekly on Friday (except when a holiday falls on Friday, then mailed the next business day)		State website, or the Peach State provider manual.	

How often can a patient change his/her PCP?

Amerigroup Community Care	**CareSource**	**Peach State Health Plan**	**WellCare of Georgia**
Anytime	Members can change their PCP one (1) time per month. However, members can change their PCP at any time under extenuating circumstances such as: • Member requests to be assigned to a family member's PCP • PCP does not provide the covered services a member seeks due to moral or religious objections	Within the first 90 days of a member's enrollment, he/she can change PCP monthly. If the member has been with the plan for 90 days or longer, the member can change PCPs once every six months. There are a few exclusions that apply and would warrant an immediate PCP change.	Members can change PCPs for any reason within the first 90 days of their enrollment. After the first 90 days, members may change PCPs once every six months.

	• PCP moves, retires, etc.		

Once the patient requests a PCP change, how long it takes for the new PCP to be assigned:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
Next business day	PCP selections are updated in CareSource's systems daily.	PCP changes made before the 24th day of the month and are effective for the current month. PCP changes made after the 24th day of the month are effective for the first of the following month.	PCP changes made between the 1st and 10th of the month will go into effect right away. Changes made after the 10th of the month will take effect at the beginning of the next month

PHARMACY

Georgia Families does provide pharmacy benefits to members. Check with the member's health plan about who to call to find out more about enrolling to provide pharmacy benefits, including information about their plans reimbursement rates, specific benefits that are available, including prior approval requirements.

To request information about contracting with the health plans, you can call the CMOs provider enrollment services.

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
800-454-3730 https://providers.amerigroup.com/pages/ga-2012.aspx	844-441-8024 https://cvs.az1.qualtrics.com/jfe/form/SV_cvyY0ohqT2VXYod	866-874-0633 www.pshpgeorgia.com	866-300-1141 ProspectiveProviderGA@WellCare.com or https://www.wellcare.com/en/Georgia/Become-a-Provider

All providers must be enrolled as a Medicaid provider to be eligible to contract with a health plan to provide services to Georgia Families members.

The CMO Pharmacy Benefit Managers (PBM) and the Bin Numbers, Processor Control Numbers and Group Numbers are:

Health Plan	PBM	BIN #	PCN
Amerigroup Community Care	ESI	003858	MA
CareSource	CVS Caremark	004336	MCAIDADV Group: RX0835
Peach State Health Plan (PBM)	Envolve Pharmacy Solutions Caremark (Claims Processor)	004336	MCAIDADV
WellCare of Georgia	Caremark	004336	MCAIDADV

If a patient does not have an identification card:

Providers can check the enrollment status of Medicaid and PeachCare for Kids® members through DXC by calling 1-800-766-4456 or going to the web portal at www.mmis.georgia.gov. DXC will let you know if the member is eligible for services and the health plan they are enrolled in. You can contact the member's health plan to get the member's identification number.

Use of the member's Medicaid or PeachCare for Kids® identification number to file a pharmacy claim:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
No, you will need the member's health plan ID number	Yes, you may also use the health plan ID number.	Yes	Yes, you may also use the WellCare subscriber ID

Health plans preferred drug list, prior authorization criteria, benefit design, and reimbursement rates: Each health plan sets their own procedures, including preferred drug list, prior authorization criteria, benefit design, and reimbursement rates.

Will Medicaid cover prescriptions for members that the health plans do not?

No, Medicaid will not provide a "wrap-around" benefit for medications not covered or approved by the health plan. Each health plan will set its own processes for determining medical necessity and appeals.

Who to call to request a PA:

Amerigroup Community Care	CareSource	Peach State Health Plan	WellCare of Georgia
1 (800) 454-3730	1 (855) 202-1058 1(866) 930-0019 (fax)	1 (866) 399-0929	1 (866) 231-1821 1 (866) 455-6558 (fax)

Appendix X

NATIONAL PROVIDER IDENTIFIER (NPI) REQUIREMENTS

The National Provider Identifier (NPI) has been adopted by the U.S. Department of Health and Human Services to meet the HIPAA health care provider identification mandate. It is a 10-digit number assigned to health care providers. Once a provider has an NPI, it will not change regardless of job or location changes. It replaces all existing health care provider identifiers including numbers assigned by Medicare, Medicaid, Blue Cross, etc. on standard HIPAA transactions. It will be the number used to identify providers nationally.

Who needs an NPI?

All Medicaid providers, both individuals and organizations, who are eligible to receive an NPI, are required to have an NPI. This includes

- All Medicaid healthcare providers and
- All CMO healthcare providers.

The NPI will be required on electronic claims.

Medicaid providers who are not eligible to receive an NPI will maintain their current Medicaid Provider ID. A table showing the types of Medicaid providers and whether they are required to get and use an NPI is included at the end of this Appendix.

When do I need to use my (National Provider Identifier) NPI with Georgia Medicaid?

- Applying to be a Medicaid Provider
- On all electronic claims submission including claims submitted via WINASAP.

When do I need to use my Medicaid Provider Number?

You will need to use your Medicaid Provider Number in the following circumstances.

- Paper claims submission (CMS 1500)
- Resubmission of electronic claims on paper
- Submission of web claims
- IVR System inquiries
    - Provider authentication
    - All claim inquiries
    - All other inquiries
- Telephone inquiries
    - Provider authentication
    - All claim inquiries

    - All other inquiries
- Prior authorizations
    - Requests
    - Inquiries
- Referrals
    - Request
    - Inquiries
- Medicaid forms

When do I need both my NPI and my Medicaid Provider Number?

- Adding a location to my Provider record
- Changing my Provider information
- Written inquiries and correspondence
- E-mail and 'Contact Us' inquiries

Rev 07/07

Refer to the Part I Policy and Procedure Manual for Medicaid and PeachCare for Kids, Billing Manual, for a list of provider types, categories of service (COS), specialty codes, and specialty descriptions for Georgia Medicaid.

APPENDIX Y

PROVIDER PREVENTABLE CONDITIONS, NEVER EVENTS, and HOSPITAL ACQUIRED CONDITIONS

Effective July 1, 2012, the Centers for Medicare and Medicaid Services (CMS) directed all state Medicaid agencies to implement its final rule outlined in 42 CFR 447.26, regarding PROVIDER PREVENTABLE CONDITIONS (PPCs), NEVER EVENTS (NEs), and HOSPITAL ACQUIRED CONDITIONS (HACs) acquired in ALL hospital settings and other non-inpatient health care settings.

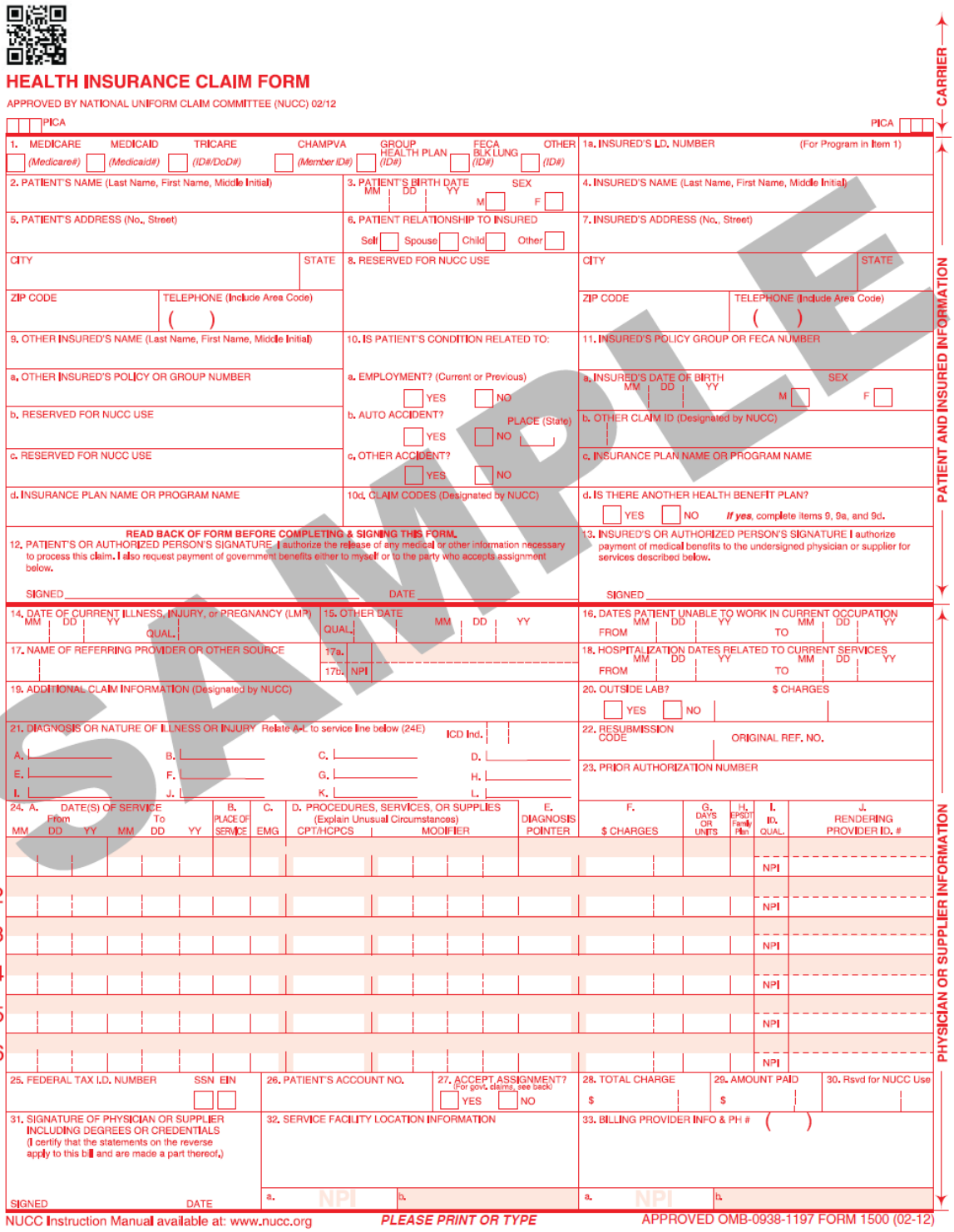
HACs are defined as diagnoses determined by either the state and/or Medicare to be reasonably preventable, i.e., Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following a total knee replacement or hip replacement surgery, and PPCs, i.e., the wrong body part and surgical invasive procedures performed by a practitioner or provider to the wrong patient that should never happen in an admission to treat a medical condition. CMS specifically in Section 2702 of the Patient Protection and Affordable Care Act, prohibits payment to providers for Other Provider-Preventable Conditions (OPPPCs) as specified in 42 CFR 434, 438, and 447 of the Federal Register, page 32816.

The *Hospital Services Manual* in Section 1102(e) outlines the Department's policies and procedures on HACs as identified by Medicare' federal regulations published in October 2010. The Georgia Medicaid Management System (GAMMIS) was configured on July 1, 2011 with the HACs edits. The Department of Community Health will not reimburse inpatient facilities (if applicable) or enrolled Medicaid practitioners/providers for treatment of any HACs and/or PPCs identified through the claims adjudication and/or medical records review process. NEs in Inpatient Hospitals, Outpatient Hospitals, Ambulatory Surgical Centers (ASC) and practitioners and providers regardless of the healthcare setting are required to report NEs. Refer to the Reimbursement sections of the *Hospital Services and Physician Services Policies and Procedures Manuals* for additional information.

Claims will be subject to retrospective review in accordance to CMS' directive and the State Plan Amendment, Appendix 4.19. When a claim's review indicates an increase of payment to the provider for an identified PPC, HAC, or NE, the amount for the event or provider preventable condition will be excluded from the provider's total payment.

No reduction in payment for a provider preventable condition will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. Non-payment of provider-preventable conditions shall not prevent access to services for Medicaid beneficiaries.

APPENDIX AA



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1									NPI	
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

New 1500 CMS Claim Form

The following table outlines the **revised changes** on the above CMS 1500 claim form version 02/12:

FLD Location	NEW Change
Header	Replaced 1500 rectangular symbol with black and white two-dimensional QR Code (Quick Response Code)
Header	Added "(NUCC)" after "APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE."
Header	Replaced "08/05" with "02/12"
Item Number 1	Changed "TRICARE CHAMPUS" to "TRICARE" and changed" (Sponsor's SSN)" to "(ID#/DoD#)."
Item Number 1	Changed "(SSN or ID)" to "(ID#)" under "GROUP HEALTH PLAN"
Item Number 1	Changed "(SSN)" to "(ID#)" under "FECA BLK LUNG."
Item Number 1	Changed "(ID)" to "(ID#)" under "OTHER.'
Item Number 8	Deleted "PATIENT STATUS" and content of field. Changed title to "RESERVED FOR NUCC USE."
Item Number 9b	Deleted "OTHER INSURED's DATE OF BIRTH, SEX." Changed title to "RESERVED FOR NUCC USE."
Item Number 9c	Deleted "EMPLOYER'S NAME OR SCHOOL." Changed title to "RESERVED FOR NUCC USE."
Item Number 10d	Changed title from "RESERVED FOR LOCAL USE" to "CLAIM CODES (Designated by NUCC)." **Field 10d is being changed to receive Worker's Compensation codes or Condition codes approved by NUCC.** **FOR DCH/DXC:** FLD 10d on the OLD Form CMS 1500 Claim (08/05) will no longer support receiving the Medicare provider ID.
Item Number 11b	Deleted "EMPLOYER'S NAME OR SCHOOL." **Changed title to "OTHER CLAIM ID** (Designated by NUCC)". Added

	dotted line in the left-hand side of the field to accommodate a 2-byte qualifier
Item Number 11d	Changed "If yes, return to and complete Item 9 a-d" to "If yes, complete items 9, 9a, and 9d." (Is there another Health Benefit Plan?)
Item Number 14	Changed title to "DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)." Removed the arrow and text in the right-hand side of the field. Added "QUAL." with a dotted line to accommodate a 3-byte qualifier." **FOR DCH/ DXC Technology: Use Qualifiers: 431 (onset of current illness); 484 (LMP); or 453 (Estimated Delivery Date)**.
Item Number 15	Changed title from 'IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE" to "OTHER DATE." Added "QUALIFIER." with two dotted lines to accommodate a 3-byte qualifier: 454 (Initial Treatment); 304 (Latest Visit or Consultation); 453 (Acute Manifestation of a Chronic Condition); 439 (Accident); 455 (Last X-ray); 471 (Prescription); 090 (Report Start [Assumed Care Date); 091 (Report End [Relinquished Care Date); 444 (First Visit or Consultation).
Item Number 17	Added a dotted line in the left-hand side of the field to accommodate a 2-byte qualifier – **Used by Medicare** for identifiers for provider roles: Ordering, Referring and Supervising. **FOR DCH/ DXC Technology:** Use the following Ordering Provider, Referring, Supervising Qualifiers (**effective 4/01/2014**): **Ordering = DK; Referring = DN or Supervising = DQ.**
Item Number 19	Changed title from "RESERVED FOR LOCAL USE" to "ADDITIONAL CLAIM INFORMATION (Designated by NUCC)." **FOR DCH/ DXC Technology:** Remove the Health Check logic from field 19 and add it in **field 24H.**
Item Number 21	Changed instruction after title (Diagnosis or Nature of Illness or Injury) from "(Relate Items 1, 2, 3 or 4 to Item 24E by Line)" to "Relate A-L to service line below (24E)."

Item Number 21	Removed arrow pointing to 24E (Diagnosis Pointer).
Item Number 21	Added "ICD Indicator." and two dotted lines in the upper right-hand corner of the field to accommodate a 1-byte indicator. Use the highest level of code specificity in FLD Locator 21. **Diagnosis Code ICD Indicator** - new logic to validate acceptable values (0, 9) ICD -10 diagnoses (CM) codes = value 0.
Item Number 21	Added 8 additional lines for diagnosis codes. Evenly space the diagnosis code lines within the field.
Item Number 21	Changed labels of the diagnosis code lines to alpha characters (A-L).
Item Number 21	Removed the period within the diagnosis code lines
Item Number 22	Changed title from "MEDICAID RESUBMISSION" to "RESUBMISSION." The submission codes are: 7 (Replacement of prior claim) 8 (Void/cancel of prior claim)
Item Numbers 24A – 24 G (Supplemental Information)	The supplemental information is to be placed in the shaded section of 24A through 24G as defined in each Item Number. For **DCH/ DXC Technology**: Item numbers **24A** & **24G** are used to capture Hemophilia drug units. **24H** (EPSDT/Family Planning).
Item Number 30	Deleted "BALANCED DUE." Changed title to "RESERVED FOR NUCC USE."
Footer	Changed "APPROVED OMB-0938-0999 FORM CMS-1500 (08/05)" to "APPROVED OMB-0938-1197 FORM 1500 (02/12)."